MENTAL HYGIENE

VOL. V JULY, 1921 No. 3

THE RÔLE OF SITUATION IN PSYCHOPATHOLOGICAL CONDITIONS

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NOT long ago a colleague interested in psychopathology said to the writer: "I wish we could work out some of those beautiful analyses of cases one sees in current psychiatric literature. It would be so satisfying." Expressive though it is of the silent longings of many of us in moments of quick discouragement, this remark, nevertheless, forms a sort of background on which to work with a group of individuals in whom the writer has been increasingly interested. They are men and women and children whose difficulties of adaptation are for the most part associated with their respective settings of environment, habit data, temperamental friction, and all the other facts of common experience. There is nothing remarkable about their stories. Most of them have not enough associative material to form even a modest structure of word architecture in the way of analysis. Equally undramatic is the relief that can often be given to these conditions of distress and perplexity by such simple measures as ventilative discussion of the difficulty with the patient and his family, change in habits of living, corrective exercises for twists of personality expressed in sensitiveness, nagging, nervous fears of disease, day-dreaming, and many another stile over which human beings are apt to pass into the by-paths of Doubting Castle.

With one brilliant exception, the literature of psychopathology is surprisingly lacking in discussions of the rôle of

situation as an etiological factor in this type of disease. In reviewing the progress of research in psychiatric medicine, one is struck by the passionate tendency to lose the individual in the mass and to gravitate toward discovery of a general cause for disorders of balance as a whole. It is only in the near past that such a general cause for psychopathological manifestations was sought exclusively in chemical and anatomical changes in the brain. From this theoretical standpoint, the etiological search has drifted to the psychogenic pole, so that to-day we find equally enthusiastic exponents of a point of view diametrically opposite, but also all-embracing in its possibilities of conquest. Between these two extremes of investigation there has gradually arisen another method of approach to the problems of etiology in this field of science. Instead of studying a patient with the unconscious determination to find an exposition of some preconceived theory, the physician is urged to study him for facts which he, as an individual case, presents. The etiological facts of this particular patient may be neurogenic or exogenic or organogenic or psychogenic or situational; they may be combinations of one or more of these factors. Upon the unbiased weighing of facts depends the outlook, good or bad. Some of them can be modified, others cannot. The criterion in every instance must always be an individual matter. To Adolf Meyer more than to any other psychopathologist is due the pioneer credit of raising the facts of concrete and specific observation to the rank of scientific data in psychiatric research. Writing in the *Psychological Bulletin* in 1907,[1] he made a plea for the reduction of dogmatic general considerations to their actual value in the life of definite patients. "Our concern," he says, "is with the event or 'doing,' not with the being or final essence. We study the relation of occurrences and experiences, and among them we find, on exactly the same ground as the rest of experiences, the occurrence of events and activities which are called mental. The fundamental principle of the non-dogmatic attitude is the adherence to a series of non-prejudicial queries which hold for all events worthy of inquiry: (1) What is the fact in question? (2)

[1] *Psychological Bulletin*, Vol. IV, pp. 170-79, June 15, 1907.

What does the event or fact lead to, or how does it react to tests? (3) What are the conditions for its existence, or course? (4) How can it be influenced, and what is our attitude to the event?"

Without benefit of training in the traditional methods of psychopathological research, the writer of this paper began at the start with a study of case material and its intrinsic values in terms of problem and constructive assets. The facts involved take one far afield, so that even in any one human story it is hard to say whether we deal with heredity, poor environment, neurotic make-up, endocrinopathy, aberration of the libido, or other etiological constellations which bear the burden of many accusations. In the cases outlined in this paper, the facts of situation seem to play a leading rôle, as indicated by the disappearance of certain unhealthy tendencies in the presence of a setting modified to suit the individual need. The seventeen cases sketched here are taken from the Out-patient Department of the Henry Phipps Psychiatric Clinic of the Johns Hopkins Hospital, in which from 50 to 60 per cent of the new admissions each month are children. By reason of this emphasis on children in our psychiatric dispensary, and for the sake of uniformity of material for descriptive purposes, the writer has confined her present observations entirely to children. The seventeen children recorded in the accompanying chart (pages 462-467) were first seen in the Henry Phipps Psychiatric Dispensary during the months of September and October, 1920. They were referred, as are most of our patients, from outside physicians, from social organizations such as the Henry Watson Children's Aid and the Family Welfare Association, from schools, and also from the various out-patient departments of the Johns Hopkins Hospital, especially from the pediatric service of the Harriet Lane Dispensary. In every instance the physical condition has been passed upon by one or more physicians on the general dispensary staff of that hospital. The majority of these cases have been carefully studied by the social workers of our psychiatric service, who have made repeated visits to the home and school, listening to the stories of family and teachers and effecting that exchange of viewpoints which makes for mutual understanding

and intelligent coöperation. To these students and their co-workers in local agencies is due the credit of the results recorded with regard to this group of patients.

Passing from this foreword to a consideration of the cases sketched in the accompanying tables, one is struck by the simplicity of the subject matter to which one's attention is called. The surprise is greater if one has been accustomed to associating psychiatric patients with well-formulated psychoses of Kraepelinian entities. The complaints for which these children were referred—twiching, retardation, speech disturbance, excitability, imaginary somatic distress, etc.—may or may not augur ill for the future. For the present, at least, they constitute a handicap to the start in life that cannot be ignored. The presence of "spells," for example, whether temper storms or pseudo-convulsive tricks, tends to single out the child from other children in the family and other scholars in the classroom. The watching and anxiety and special consideration of parents and teachers cannot but have its effect on the child himself. In some instances it fosters embarrassment with feelings of inferiority; in others it acts as a wedge for native aggressiveness and lack of consideration; and in every instance it focuses the attention of the child on himself with a wealth of unhealthy reactions so familiar in the psychopathology of everyday life. In reviewing the background of situations from which the above-mentioned complaints have arisen, one is again impressed by the absence of any great and startling facts, especially if one has been accustomed to associating psychopathological conditions with definite etiological factors—such as somatic disease, emotional strains of shock and conflict, and desperate adaptive problems of poverty and hardship. The situational data presented here involve such facts as poor habit training, faulty understanding of the individual child, and unwholesome attitudes of parents and teachers expressed in chronic worry, over-solicitude, nagging, repression of initiative, too much stimulation, pushing beyond native capacities, etc. Petty and commonplace facts they seem in the telling, and yet capable of producing tremendous influence on the springs of human activity.

Case Histories

C. K. (No. 1) is a boy of eight who was brought to the dispensary by his mother with the complaint that he was "backward in everything." He was teased by younger children, would give up his rights sooner than fight or argue, and sat around the house doing nothing after school. The boy slept poorly and was afraid of everything.

Examination of Patient and Situation: The patient was pronounced physically normal in the Harriet Lane Dispensary. He had a mental age of eight years plus, according to the Binet-Simon tests. In appearance he seemed bright and full of normal interests. He was in the third grade of a small private school, not being allowed to go to public school because it was "too rough." He owned a football, a baseball, and a bat, all of which were in good condition because he was allowed to use them only in the small backyard of his home. Apparently he had never had an opportunity to receive a black eye or get his feet wet. On investigation it developed that the father and mother were separated, and the latter and the patient lived with the maternal grandmother. The father was a ne'er-do-well and alcoholic, and the mother felt that the patient should be shielded from influences that might tend to develop inherited characteristics. Hence his companions and play had been carefully supervised. The child felt that in some vague way he was different from other children, and that this difference was associated with the father, who must have been a very bad man. The mother ascribed the patient's odd behavior to "nerves," which were a sure sign of tainted inheritance.

Suggested Modification and Results: An attempt was made to show the mother that this child's faulty characteristics were the product of her own solicitude and fear. It was suggested that she try a program of encouraging the patient's initiative—transfer to a larger school, right of way to playground without continued watching and fear of disaster.

The mother reports at the end of five months that the patient has not only outgrown his previous tendencies, but seems to have made up for lost time in his noisiness and irre-

pressibility. In appearance the boy is franker and more communicative. He speaks voluntarily of the part he is taking in games, and boasts of his prowess in having settled a personal dispute or two with "fellers bigger than I am."

M. S. (No. 16) is a boy of eight who was referred by a Hebrew charitable organization for nervousness, consisting of twisting the mouth to one side, twitching and jerking the shoulders, and blinking the eyes. The patient is one of four children. His elder brother, Joe, had nervous fears and vague imaginations which disappeared as soon as he was removed to a boarding home in the country, but reappear whenever he returns home. The mother nags at the children in loud, querulous tones and then allows them to have their own way. She is over-ambitious for their progress. The patient, for example, is in the high third grade, and as soon as he comes from school at three-thirty, he goes to a Hebrew school where he remains until after six.

Examination of Patient and Situation: The symptoms for which the patient was referred were first noticed during a brief home visit of brother Joe, and were more in evidence under special strain of discipline at school and at home. During examination the child appeared shy and silent, but as soon as his family left the room, it was easy to get him on a talking basis. His attitude toward brother Joe seemed a mixture of envy and admiration. "Joe can fish"—and the like—"and nobody hollers at him. He's nervous, too, and when he goes to the moving pictures, he can see white spots, and I can't see no spots," etc. To physical examination the patient appeared normal. His meals were irregular, and his bedtime often as late as 11 p. m.

Suggested Modification and Results: Regulation of eating and sleeping habits was advised, and also the substitution of play for the Hebrew lessons in the afternoon. The mother was urged to ignore the nervous tricks as much as possible, at least to the extent of not harassing the child concerning them.

At present writing—four months from the date of the first examination—the mother reports a discontinuance of the former complaints. The child himself gives the impression of less tension and sense of being over-stimulated. The

out-door play evidently gives him a great deal of satisfaction. It is an outlet for energy in an atmosphere of abandonment free from supervision.

Discussion: In the above cases one sees two children of approximately the same age, physical status, and original mental equipment. One has had the benefit of quieter home surroundings, perhaps, and more careful supervision of living habits. Yet both display abnormal behavior that is directly the product of their environments, though the type of the reactions is quite different. C. K. reacts with indifference, sluggishness, and timidity to his mother's repression of boyish instincts to fight and play and run with the group. M. S. reacts with mild choreiform movements to the over-ambitious program of an anxious mother to whom goading is the embodiment of discipline. The object of the therapy in each case was the mother, who, with a little guidance, has been able to readjust matters for the unbalancing of which she was unwittingly responsible.

The next two cases deal with material depressingly familiar to every physician under the term "hypochondriasis." In its adult and middle-life setting, the symptoms are monotonous, the treatment is apt to be unremitting, and the individual etiology becomes year by year more drab and obscure. The following children were referred from the pediatric dispensary of the Johns Hopkins Hospital because of persistent somatic complaints for which no organic basis had been discovered.

M. S. (No. 10) is a little girl of three years who complained of pain in her knees at night, so severe that she woke crying several times each night. The condition had developed gradually during the past ten months, at first occurring two or three times a week and then becoming a nightly phenomenon. During the day the child slept a good deal, as if to make up for previous wakefulness.

Examination of Patient and Situation: Little could be obtained from the child directly. She appeared tired and sleepy—in fact took several naps in her mother's arms during the examination. The patient had always been healthy except for the present illness. There were no special developmental traits except that the child had always shown a keen imagina-

tion, imitating what she saw and heard without any encouragement. For example, a neighbor came into the house one day and told of some friction between herself and her husband. After she had gone the patient was found in another room scolding a make-believe husband in loud tones. Up to the birth of a brother fifteen months before, the patient had been the only child and her father's pet. She had slept in the parents' bed, but now slept in a crib in their room, while the baby slept with the parents. At the birth of this brother, the patient refused food for four days, beat her head against the floor, and later tried to hit the baby with a broom. The mother stated that she had outgrown this jealousy and now seemed very fond of the baby. There was no history of disciplinary troubles.

The father is a laborer who works all day, but for the past year or more he has had inflammatory rheumatism in his knees to which a great deal of attention has been paid. Since the onset of the patient's illness, both father and mother have been up with her frequently during the night, rubbing her knees and applying hot cloths for relief of the pain.

Suggested Modification and Results: The probable mechanism of this curious behavior was explained to the mother. Care was taken to show her that these activities to get the father's attention were simple outcroppings of natural initiative, appearing in an extremely imaginative child, and not early buddings of original sin. It was suggested that the patient be put to sleep in a room by herself, and that her tears be ignored without discussion or attempted argument.

The mother reports that after a week of the above régime the symptoms gradually subsided and have not reappeared thus far. It was not thought best to talk over the illness with this little patient even after the disappearance of her symptoms. The parents seem to be handling the situation wisely, especially with reference to the child's attitude toward her father and the small brother. She is not teased or "shown off," as is so often the case with sensitive, precocious children, but is quietly encouraged to spend her initiative and imagination in playing with others of her own age.

M. W. (No. 11) is a girl of eleven years who was brought by a public-health nurse for "heart trouble," which had existed for almost two years.

Examination of Patient and Situation: The patient belongs to a family subject to temper tantrums, crying spells, neurotic vomiting, etc. Her first "spell" came about the time her mother remarried after the death of the first husband. The patient resented this marriage. The stepfather is unable to support the family and is abusive to her mother. One morning while preparing for school, the patient had "words" with her mother over some matter of dressing. The patient "doubled up like a ball" and had to be assisted to bed. A doctor who was called pronounced the condition heart trouble and told the patient she might die at any time if she were not careful. He forbade her going to school or taking light exercise—such as going to the store on errands. The child spent most of her time in bed with three pillows, reading trashy books. She complained of palpitation and weakness even in walking about the house. The stepfather regarded her as an idler, and the child was often the subject of a family brawl.

Suggested Modification and Results: The mother and patient were reassured as to the supposed heart condition, and a daily routine of return to school and normal activities was outlined. The nurse volunteered to follow the case and see that the patient was gradually steered away from her previous invalid habits.

The child has now been in school since November first, and so far has had no recurrence of the former symptoms. Unfortunately this child comes from a rural district from which return to the city dispensary is hard to achieve. She has not returned since her first visit, but is being carefully followed by the public-health nurse, with whom we are in touch.

Discussion: In these two children one sees hypochondriacal tendencies arising quite naturally from their respective backgrounds. The one child at three years of age uses her constructive imagination and imitative powers to advance her importance in the circle of family and neighbors. Having once tasted the joys of special consideration, even without a clear idea of the means by which they were attained, this little girl clings to her behavior until pain and tears become realities in her world of practical experience. The other child of eleven reacts to a conflict of argument with a flurry

of behavior for which she may have seen the pattern in her mother or older sisters. It needed but the professional touch of diagnosis and treatment to push this small patient into a rut of invalidism, from which she was rescued only by the long arm of compulsory education.

H. K. (No. 8) and J. D. (No. 12) exemplify psychopathological behavior which has been discussed from many standpoints. Stealing, lying, sex irregularities, the starting of fires, etc., are associated with defectiveness, "constitutional psychopathic inferiority," and the general incorrigibility of the delinquent, whether it be a social or mental disease. The conduct disorders of these two particular children have not proven as grave as the face value of the complaints seemed to indicate.

J. D. (No. 12) is a girl of seven years who was referred for incorrigibility, which consisted of stealing, untruthfulness, and temper tantrums.

Examination of Patient and Situation: No data could be obtained as to the background of early development and training. The child's parents died of influenza in the winter of 1918, and she became the ward of a children's organization. In the first boarding home she seems to have given no trouble, but in January, 1919, she was placed in a new boarding home. These people were kind to her, but apparently made little effort to understand her. Soon complaints arose that the patient was excitable, slept poorly, and had outbursts of temper. She was discovered taking a few cents when sent to the store on errands. To cover up the matter, she made false excuses, and when they were discovered, she had screaming spells. One morning the curls of another little girl in the family were found clipped off, and the scissors with which the deed had been done were located in the shoe of an older child in the household. When accused, the patient denied the act and was returned in disgrace and hardness of heart to the organization from which she had come. She was brought to the hospital for general examination. The physical status was normal. During the examination she maintained her innocence until the worker had withdrawn from the room, whereupon she told her side of the story. She hated the new boarding home and especially the little girl

with the curls, to whom she was always being compared. The extraordinary behavior was merely a forcible way of registering this protest.

Suggested Modification and Results: The situation was explained to the worker, with the recommendation that the patient be tried in another boarding home, where her needs were understood. This plan has worked thus far with good results. The child seems to be adapting herself to the new environment without difficulty.

H. K. (No. 8) was eight years old when he was referred for examination in December, 1917. From teacher and home came reports of stealing, sex irregularities, attempts to start fires, and repeating the first grade in school. He had taken books from the teacher's desk, money from a neighbor's, a box of tools from a garage. He not only masturbated freely, but was accused of trying to have relations with little girls of his own age. On several occasions he had started fires—once under a motor truck and once in his room. He had been in court for stealing, and had received all sorts of punishment without improvement.

Examination of Patient and Situation: The patient's father is in the navy and is seldom home. His own mother died in 1915. Nothing of importance was learned as to his early development, but the complaints appeared strangely coincident with the arrival of the stepmother. Living conditions were above the average of dispensary patients. The patient's physical examination was normal, and he had an intelligence quotient of 100. He appeared frank, admitting all the things of which he was accused except the relations with girls, which he constantly denied. He denied any motive for his conduct, nor did he show tears or anger or seek to excuse himself. The father was inaccessible; the stepmother appeared honest until asked to carry out a practical suggestion.

Suggested Modification and Results: The family wished to have the boy sent to a disciplinary institution. It was suggested that he be tried out in a boarding home, with special supervision as to his requirements. The parents would not consent and refused coöperation in any other way. The patient disappeared from our view until some nine months

ago, when he was brought in by a children's welfare worker with the same old complaints. A boarding home was found for him in a suburb of the city. In this home he was the only child, and the object of the wise and kindly supervision of two people who understand boys. The results at the end of six months seem to prove that the experiment was worth trying. To date there has been no recurrence of stealing, setting fires, or sex misdemeanors. The patient still masturbates at times, but with his opportunities for day-dreaming and fancies reduced by concrete activities and wholesome interests, this habit is much less marked.

Discussion: The stories of these children arouse thought concerning the sources of incorrigibility, which the psychiatrist, the probation officer, and the reformatory worker see in the early flower of adult life. What starts the individual energy into these circuitous channels? In J. D. one has a plain "get square" reaction; in H. K. an unmotivated push of activities and instincts readily diverted into normal behavior, even after they have existed long enough to fulfill the laws of habit formation.

Reflection in summary cannot but dwell on the elastic possibilities of the word "situation." In the cases cited above the term is associated with a wide range of facts connected with the start in life that these particular children have had. A glance at the column of situational data reveals handicaps of living conditions, poor habit training, and strains of parental attitude, the tracery of which one often sees in unsound adult reactions. The self-assertion and initiative of M. S., aged three, for example, expressed themselves quite differently from the same traits in H. K., yet both were in part the resultant of unfortunate forces at work in the background of their respective environments. Speculation as to the reason why one child of our group reacts to nagging and anxious fear with vague choreiform movements, while another becomes dull and apathetic, may take one far afield without discovering the combination of factors that started the abnormal behavior. Parents and teachers are concerned with the course of the behavior and how it can be modified. Should the twitching or speech trick be ignored, or should it be made the object of argument and reprimand? Ought

shyness and lack of initiative to be handled by aggressive or suggestive tactics?

In answering these and many other questions that come up in individual case studies, the physician faces the issue of getting family and school to carry out the suggestions offered. As a matter of fact, this phase of the work is less of a problem than those who have not tried it suspect. For example, the mother is not asked to give her consent to a procedure of which she would be merely the spectator, such as an operation or some other form of manipulative therapy. Neither is she requested to be a party to dark and mysterious rites that appeal to her faith through imagination. Moreover, by the time she comes to the psychopathologist she has usually been disillusioned in regard to blood and worm medicines, and often has a spirit chastened by ineffectual attempts to handle a condition that is becoming progressively more baffling. In this frame of mind she is quite susceptible to a frank talk about the facts of the case as the physician sees them, even when these facts indicate a change of attitude and a course of procedure directly the opposite of that she has been following. Especially is her coöperation elicited if she is given specific suggestions as to habits of food, sleep, play, school work, the management of temper tantrums, sulkiness, etc. To illustrate, the mother of C. K. (No. 1) showed no resentment at the suggestion that her boy appeared retarded and different from others of his age because she had adopted an attitude toward him that often tends to foster such symptoms. She was willing to try out another plan which brought the child into contact with more children, gave him greater freedom in play, and created an opportunity for him to grow in self-management. Likewise, it is usually not difficult to get the school to contribute its share toward reconstruction of the situational background. Fifteen minutes' talk with a child's teacher will often do more to iron out the wrinkles of a bit of classroom friction than several pages of typewritten report, especially if the talk be given as a tentative suggestion rather than in the spirit of scientific dictum. It is the personal contacts with child and teacher and parents that count. In short, the physician's ultimate consideration must be with the "doings" in every instance, no matter how elaborate his analytical study of the "final essence."

CASES OF SEVENTEEN CHILDREN REFERRED TO

NOTE: In this chart B. stands for

Case	Sex	Age	Difficulty	Physical status
1 C. K.	B.	8	"Backward in everything."	Normal. B. S. 8 years plus.
2. A. G	B.	13	Twitching of eyelids and occasional stuttering. Vague somatic complaints.	Normal.
3. H. K.	G.	9	Stumbling and "general dumbness."	Normal. B. S. 8 years plus.
4. M. R.	G.	12	Stammers in school.	Normal.
5. B. C.	G.	13	Enuresis.	Gynecological condition negative.
6. E. F.	B.	7	"Stomach trouble and nervousness—chews clothes."	Slightly under-weight.
7. E. H.	B.	9	Occasional stammering Nervousness.	Somewhat under-nourished.
8. H. K.	B.	8	December, 1917. Stealing, backwardness, sex irregularities.	Normal. B. S. 8 years.

THE HENRY PHIPPS PSYCHIATRIC DISPENSARY

boy, G. for girl, B. S. for Binet-Simon.

Situational data	Suggested modifications	Follow-up notes—Feb., 1921
Parents separated. Anxious mother and grandmother. Poor habit training. Repressed at home.	Avoid over-solicitude and nagging. Encourage group play.	Mother reports patient full of initiative—leader in games on playground. Seems to have outgrown his "cowardice," timidity, and seclusiveness.
Bed at 11 p. m. Clings to mother. Little interest in play. Mother and teacher worry over the "nervousness."	Regular sleeping habits and more outdoor play. Nervous tricks should be ignored.	Slight residual of eye tic, but speech hesitancy not noted. No somatic complaints. Patient has taken up mechanical drawing with hopes of technical training later.
Patient has been ward of social agency four years. Various boarding homes with poor adaptation. Teased about shyness. Has no idea of play.	Foster mother advised to win patient's confidence by encouragement and patient inquiry into difficulties. Stumbling to be ignored.	Foster mother reports disappearance of stumbling. Marked initiative in play. Teacher notes improvement in school work.
Patient only child. Mother chronic worrier—constantly pushing patient—fearful of disease.	Mother shown that her ambitious anxiety embarrasses patient. Teacher to coöperate. Liberal program of diversions for mother and patient.	Teacher reports no further hesitancy in speech and patient more at ease in classroom.
Family move frequently. Detached schooling with feelings of discontent—too "old-fashioned" to play. No supervision in habits of living.	Regulation of habits. Attempt to create healthy satisfactions associated with school, neighborhood, and church.	Gradual declining in enuresis—no lapses for last six weeks; more interest in school work; joining Girl Scouts.
Poor habits of eating and sleeping. Temper tantrums since four years. Irritable, nagging mother—over-critical of patient.	General hygienic measures as to food and sleep. Mother warned against over-solicitude and worry about patient.	Mother easing up on watchfulness. Reports patient less "nervous" than he has been for years.
Poor food (candy and pickles). Tantrums if denied. Movies four times a week. Late bedtime. Sleeps with grandfather. Stammers when "crossed" at home or in school.	Regulation of food, sleeping arrangements, and movies. Mother given insight into "spoiled child" behavior. To ignore stammering.	Improved general appearance and behavior. Less excitable. Stammering has apparently disappeared.
Stepmother secretly hostile to patient. Father unaware. No attempt in home to discover motives for patient's behavior.	Readjustment of situation in home attempted without success for two years.	Child placed in boarding home under careful supervision. During past six months boarding mother has noticed no tendencies formerly ascribed to patient.

CASES OF SEVENTEEN CHILDREN REFERRED TO THE

NOTE: In this chart B. stands for

Case	Sex	Age	Difficulty	Physical status
9. S. A.	B.	5	Speech difficulty.	Normal.
10. M. S.	G.	3	Pains in her knees. Screaming at night.	Negative.
11. M. W.	G.	11	"Heart trouble."	Normal
12. J. D.	G.	7	Lying, stealing, incorrigibility.	Normal.
13. H. P.	G.	7	"Loss of memory following flu," March, 1920.	Normal. B. S. 6 years plus.
14. R. A.	G.	11	Excitability and enuresis.	Normal. B. S. 10 years.
15. A. G.	G.	6	"Convulsions."	Normal.

HENRY PHIPPS PSYCHIATRIC DISPENSARY—*Continued*

boy, G. for girl, B. S. for Binet-Simon.

Situational data	Suggested modifications	Follow-up notes—Feb., 1921
No attention at home. Shy—does not play well. Teased and nagged about speech.	Kindergarten. Parents told to encourage, not criticize. Regulate living habits.	Patient gradually thawing in school. Talking slightly improved.
Patient sensitive and very imitative. Father's pet till birth of brother 15 months previous. Sleeps in room with parents. Father being treated for arthritis of knees.	Child to sleep in room by herself. Probable mechanism of complaints explained to parents. Apparent somatic distress to be ignored.	Mother reports patient free from pains for two months. Sleeps quietly.
Symptoms began three years previous with death of father and mother's remarriage. Attacks of "collapse" diagnosed heart trouble by doctor. Patient becomes invalid. Taken from school. Three pillows at night.	Mother reassured following Johns Hopkins Hospital examination. Patient to go to school and take up normal interests in play.	Patient in school since November 1, 1920. Good progress. No recurrence of attacks.
Parents died in 1918. Patient ward of children's agency. Unfortunate boarding homes with antagonistic reaction by patient.	Attempt to find boarding home where patient will be understood.	Child reacted to new environment with more coöperation. No recurrence of previous complaints.
No abnormal behavior or nervous tricks. Patient spoiled by mother since flu. Great alarm over petty complaints. Patient tells teacher she is nervous. Kept out of school.	Return to school. Mother urged to worry less over patient.	Teacher reports some improvement in school work, though mother is still too solicitous.
Four cups of coffee daily. Late bedtime. Constant nagging by stepmother. Father irresolute.	Regulation of living habits. Attempt to show stepmother ill effects of her critical attitude. If unsuccessful, try patient in boarding home.	Enuresis only occasional. Patient quieter in demeanor. Noticeable progress in school. Stepmother pleased with improvement.
No loss of consciousness, but attacks of wriggling and sliding to ground coincident with change from mother's bed to sleeping alone. Parents ignorant and superstitious. Much therapy for "worries" and epilepsy.	Return to school. Parents urged to ignore attacks. Teacher to coöperate.	Marked improvement. Occasional attack in relation to temper tantrums. None observed in school.

CASES OF SEVENTEEN CHILDREN REFERRED TO THE

NOTE: In this chart B. stands for

Case	Sex	Age	Difficulty	Physical status
16. M. S.	B.	8	Twisting mouth and twitching shoulders.	Normal.
17. D. S.	G.	2½	Retardation in speech. Screaming.	Normal.

HENRY PHIPPS PSYCHIATRIC DISPENSARY—*Concluded*

boy, G. for girl, B. S. for Binet-Simon.

Situational data	Suggested modifications	Follow-up notes—Feb., 1921
Mother nagging and over-solicitous. Patient envious of older brother boarded in country. Patient in third grade. Hebrew lessons daily, 3:30 to 6 p. m.	Substitute play for Hebrew school in p. m. Mother warned against pushing patient.	Mother reports discontinuance of tricks under new régime.
Only child in family of grown-ups with grandparents on both sides living. Not allowed to play with other children. Continuously waited on and spoiled.	Give patient incentive for talking. Less attention. To play with other children.	No further screaming sprees. Some improvement in talking. Mother skeptical and anxious—fears contact with other children.

MENTAL HYGIENE IN INDUSTRY *

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MENTAL hygiene is the natural supplement to physical hygiene. In promoting the physical health of the individual, our interest depends upon the implicit belief that human life has a value, that the individual cannot carry out his social duties in the best way without physical health. Physical hygiene does not concern itself with these special social duties, but confines itself to seeing that the simple machinery of the individual is attended to, is repaired after damage, is kept in good order and not subjected to undue stress and strain. It is poor economy to wait until the machine breaks down and then try to patch it up. It is better to keep it in good working order and to see that it is not used for unsuitable purposes. From this point of view, emphasis is laid not so much on the treatment of individual cases of disease, but on taking the necessary social measures to prevent the occurrence of disease. In order to carry out these measures, the physician must have the coöperation of the community, and this coöperation will depend upon the community's intelligence and its feeling of social responsibility. For this coöperation, it is necessary that the community should get information with regard to sickness, and that the individual should feel some interest in promoting the public health and not merely in safeguarding his own home.

In relation to such matters as typhoid fever and smallpox, it is not difficult to put the simple facts clearly before those who are not familiar with medical matters and to persuade them of the practical advantages of a pure water supply and of general vaccination. Sometimes an epidemic is required

* Read at the Annual Conference of the Massachusetts Society for Mental Hygiene on the Human Element in Industry, April 7, 1921. Other papers in this symposium were *Has Mental Hygiene a Practical Use in Industry?* by Boyd Fisher (see page 479), and *Industrial Hygiene*, by Dr. Wade Wright (see page 497).

to drive home the situation, to make men pay increased taxes for a water supply or accept such useful measures as vaccination, which may happen to be disagreeable to them on various personal grounds.

The extent to which this conception of preventive medicine has developed is indicated by the fact that practical steps are now being taken, not only against such scourges as infectious diseases, but in relation to many other causes of ill health, and an organized effort is being made to eliminate the preventable causes of ill health in special industries. This movement would hardly be possible were it not that, in relation to the more dramatic facts of infectious diseases, the public had realized their responsibility for preventing what can be prevented and were thus educated in the idea of prevention to such an extent that they realized the advisability of going further and applying their health conscience to the industrial environment. This public conscience, this responsiveness of the community to the facts of disease even when they do not touch one personally, is the greatest encouragement to those who are dealing with the field of mental hygiene, where the situation is more complicated than is the case with infectious disorders, and where there has not been such a long history of intensive study. It is not so long since mental disorder was considered less a disease than a disgrace or a crime. Even now, in some places, the mentally sick person is brought into court on a "charge" of insanity, and a jury of laymen pass on the situation.

The treatment of these disorders has made considerable progress. The study of them now proceeds along the same lines of intensive research as the study of other disorders. We have reached the stage when we feel it our duty to see what can be done in the way of prevention. It may be felt by some that the problem is too difficult, the facts too uncertain, the situation too complex for any one cause to be made responsible, and that the remedies are not sufficiently definite for the public to be asked for coöperation in relation to these troubles. Some of the facts, however, are very definite, and the community should know these facts, even where there is no simple remedy to be proposed. The community at large should realize what influences in general are of importance,

in order that changes, where practicable, be made, and in order that the general attitude of the public toward these problems should be as enlightened as possible. It is with this end in view that a national committee and a group of state societies interested in mental hygiene have been organized.

In discussing the general topic of hygiene with non-medical people, it is not necessary to give elaborate explanations. One can refer to typhoid fever and to smallpox, to lead poisoning and other industrial disorders, and assume some familiarity. It is somewhat different when one is dealing with mental disorders, for there is still widely prevalent a rather medieval attitude toward mental disorders, which are considered to be absolutely different from ordinary forms of sickness.

Mental hygiene is not concerned merely with those serious forms of mental disorder which require treatment in state hospitals; it is concerned with those other forms of mental disorders which do not necessarily mean the removal of the individual from his ordinary social environment. A disorder is a mental disorder if its roots are mental. A headache indicates a mental disorder if it comes because one is dodging something disagreeable. A pain in the back is a mental disorder if its persistence is due to discouragement and a feeling of uncertainty and a desire to have sick benefit, rather than to put one's back into one's work. Sleeplessness is a mental disorder if its basis lies in personal worries and emotional tangles. Many mental reactions are indications of poor mental health, although they are not usually classified as mental disorders. Discontent with one's environment may be a mental disorder, if its cause lie, not in some external situation, but in personal failure to deal with one's emotional problems. Suspicion, distrust, misinterpretation, are mental disorders when they are the disguised expression of repressed longings, into which the patient has no clear insight. Stealing sometimes indicates a mental disorder, the odd expression of underlying conflicts in the patient's nature. The feeling of fatigue sometimes represents, not overwork, but discouragement, inability to meet situations, lack of interest in the opportunities available. Unsociability, marital incom-

patibility, alcoholism, an aggressive and embittered social attitude, may all indicate a disorder of the mental balance, which may be open to modification. Acute phenomena characterized by unreasoning emotional reactions, such as lynching and other mob reactions, waves of popular suspicion sweeping over a country, may be looked upon as transitory disorders. The same factors that are involved in these familiar reactions play an important part in the development of insanity.

The immediate problem of the physician is to discover the causes of, and the treatment for, these disorders. His social responsibility imposes on him the problem of seeing how far these conditions can be prevented, either by widely diffusing medical knowledge, so that the individual may safeguard himself, or by helping to organize social conditions, so that the individual gets a fair chance of developing a healthy mental balance and so that he is not exposed to undue stress and strain. The most important piece of social apparatus for the prevention of mental disorders is the school system, under whose moulding influence every one remains for a period of many years. In the adult period there seems no more promising opportunity for influencing a large body of the population than that provided in the various industrial units. Although these are organized for production and profit, and the keynote is output and efficiency, the latter need not be incompatible with an interest in health and happiness. From one point of view, the worker is a machine, but this does not need to dehumanize the worker; the industrial organization may recognize that it is important to pay attention to the most valuable and delicate part of the human machine, to that part which makes the man of more than economic value, makes him a spiritual asset to his community. Even from the point of view of output and efficiency, it has been found important to pay attention to the condition of the worker, to the general physical environment, to the elimination of trade irritants, to the opportunity for early attention to minor ailments and injuries. It has also been found economical to study the conditions that determine fatigue, the advantages of rest periods, the suitability of different types of men for different jobs. The keynote of all that work has

been essentially efficiency; the interest has been in what the man meant for the work, and not what the work meant for the man. It is the latter question that has become the most important problem in the industrial world at the present time. It is not because of lack of intelligence or defect of skill that the worker develops the symptoms referred to above. It is often in relation to the poor amount of satisfaction he gets out of life. It is in relation to the balance of his instinctive cravings and of his emotional reactions; it often depends on an unsatisfactory relationship to his fellows, his employers, his family.

To illustrate these rather general remarks, one may take a concrete situation. Chronic alcoholism has been a distressing personal and social symptom. The treatment has been prohibition. The question of why the individual reached out for this chemical stimulant has been a matter of secondary interest. Was it a morbid craving, a manifestation of original sin; or was it a habit casually acquired, but difficult to break; or was it one way of getting cheaply a sort of satisfaction that none of the ordinary opportunities of life offered him? Did the alcohol dull vague feelings of depression and discontent, and perhaps in addition supply a glorious feeling of satisfaction and raise him into a different world from the humdrum atmosphere of the factory and the depressing atmosphere of the crowded home, with the careworn housewife and the noisy children? The alcohol satisfied some cravings apparently, only temporarily, it is true, and in the long run at a great price, the price of deterioration of character; but the cravings of the individual, the longings for some sort of exhilaration and freedom from care, were perhaps fundamental human traits that found little means of honest satisfaction in other directions. Did the chronic alcoholic live in a community that offered him decent opportunities for satis faction along healthy lines, and had he been trained during his developing years to be able to utilize these sources of satisfaction? If the community offered few worthy opportunities for pleasure and recreation, then the chronic alcoholism could be looked upon as symptomatic of a faulty community organization. It is, of course, comforting for the community to be able to lay the blame on the alcoholic, and to

be blind to the fact that we are partly responsible for the organization of the community. But it is surely not enough to punish the alcoholic or segregate him or banish his liquor; the fundamental problem is not dealt with until we know the condition of which the alcoholism is merely a symptom. For the purposes of prohibition, of removing opportunities for alcoholic satisfaction, an army of officials must be employed, with an elaborate organization and skilled direction. If one looks for a comparable expenditure of money and thought directed toward supplying other sources of satisfaction to the ex-alcoholic, one is rather disappointed. Many persons who are seriously offended by the sight of drunken men on the streets are absolutely insensitive to the fact that alcoholism may have deep-seated social causes, with regard to which they have a certain personal responsibility.

In many of these cases of chronic alcoholism, we might find it worth while to study the conditions of the man's life, and to see what opportunities there were for a healthy outlet of his natural cravings. What are the satisfactions that a man craves? He enjoys the simple pleasures of the satisfaction of the appetites, pleasure in work, pleasure in family life, pleasure in games and other recreations, and pleasure in social intercourse; he enjoys a feeling of self-respect, that comfortable feeling that life is worth living and that what one is doing is worth while, whether it be as wheel greaser or locomotive engineer.

As to the possibility of getting pleasure out of one's work, conditions vary extremely. The average professional man is engaged in work that was deliberately chosen, that appeals to him and corresponds to his native disposition. He gets joy from it, although in every kind of work there are periods of hard drudgery. Such periods are, however, rendered tolerable by the knowledge that they are essential to a successful career; the knowledge of the rewards—academic, social, or financial—that the labor may bring carries one through the periods of drudgery. But joy in work, which belongs to the skilled craftsman or the professional worker, is a luxury that many other workers do not have. Many a worker has to content himself with work not deliberately chosen, but thrust upon him by constraint of the social

environment. The nature of the work may be such that there is little possibility in it of giving satisfaction to any one with average aspirations.

In the modern industrial system, large numbers of men are thus engaged during a large part of their working hours, working merely that they may live, getting no special pleasure from the work, looking for satisfaction to the period of the day when they are released from their drudgery. The possibility of satisfaction after work depends, first, upon absence of excessive fatigue; secondly, upon certain economic conditions; thirdly, upon decent opportunities in the environment for recreation; fourthly, upon having had the training that enables one to utilize the means of satisfaction available in the environment. There may be wonderful libraries, picture galleries, and symphony concerts close at hand, but unless the individual has been trained to utilize such opportunities, they are practically nonexistent. One simplest source of easy satisfaction was the saloon, where the worker could quickly get a transitory feeling of well-being. The leisure of many is spent in perusal of the newspapers, and there they get a vicarious satisfaction in reading of divorces among the rich, of daring crimes, and highly emotional presentations of racial, religious, and national issues. The presentation of social life that is found in the newspapers can hardly be said to be a well-balanced presentation of the main issues of the times. If not inclined for reading, the worker may go to the moving pictures, where he sees a still more lurid presentation of human life, and where he can, for a while, revel in the imagination of living in palatial surroundings, indulging in doubtful practices, and having a highly romantic and thrilling time. In summer he may get additional emotional excitement from being a spectator at a popular ball game.

Man is wonderfully adaptable, and many men cheerfully continue in toilsome, dangerous, monotonous occupations, creatures of habit, doing as their fathers have done; but it is important to remember that in these routine workers there are the same fundamental cravings, latent and liable to express themselves some day in a rather disconcerting form. Others may feel the monotony of their task, but get some interest from the relationship of their work to the total work

of the plant, or from association with their fellows, or perhaps from some personal attachment to an employer. Others do not get their satisfaction from these objective sources, but, while working at monotonous tasks, live in a world of their own imagination, day-dreaming of romance and riches. In others it is the religious attitude toward life that makes the situation tolerable. The lack of satisfaction seems unimportant and the discouragements of this life seem trivial in the light of the fuller life that is promised by religion, which reconciles the worker to social inequalities and enables him, under hard economic and social conditions, to continue cheerfully productive.

Some get a touch of romance and glory by joining social organizations in which they are nominated to posts with high-sounding names. Others have no such compensations, but drift along in a rather dull, sodden way, until they, too, find a source of some satisfaction; their minor ailments begin to engross their attention, they frequent the dispensaries, and a long period of intermittent invalidism may ensue. After all, to be an invalid has its gain; our misery entitles us to some respect—it may even entitle us to some compensation.

Other workers, of different temperament and tradition, react to their working conditions in a way that has still greater social importance. They, too, indulge in stimulants, but there are other stimulants than alcohol; one may be intoxicated with words as well as with wine. The stimulus of cheap oratory, of fiery propaganda, of dazzling promises, of idealist conceptions, may make the head swim, the pulse beat quicker, the eyes see red; there are certain highly intoxicating social doctrines, which hold out hopes of a new order, in which the promises of religion are to be partly realized in this world. Enthusiasm for these theories leads to the opposite of the resignation that may go with religious belief. The new order is to be realized as soon as possible; persons, institutions, beliefs that stand in the way arouse keen resentment and, each man's hopes and hates being reinforced by those of his fellows, a powerful force develops, which is the cause of much social rumbling. These dazzling theories take little account of realities, of biological facts, of economic laws, of historical development; men whose latent cravings have had

little outlet for many years, whose pent-up emotions have made it difficult to observe accurately and to judge impartially, are easily intoxicated with economic, social, and political theories that correspond to their wishes, and develop a habit of wishful thinking, which is perhaps more serious than a drug habit.

Here, again, we may try prohibition, may close the saloons of oratory, make it a penal offence to offer others a draft of intoxicating promises and theories; but the question again arises, will we do more than merely close another outlet for the underlying cravings of human nature? The subject of mental hygiene in industry is too wide to be covered in a short address; the above remarks merely illustrate an aspect of the problem that is too much neglected, and deal with industry from the point of view of what the work means to the man. From the point of view of what the man means to the work, there are many interesting problems that are attracting attention; the question of fatigue, the problem of placing those who are constitutionally unstable or poorly endowed, of utilizing those who have already had a breakdown, of offering good facilities for the early treatment and care of mental and nervous disorders, the best methods for studying intensively the special abilities and disabilities of the individual, are topics on which much has been written and much work remains to be done. But the aspect of the problem that has been discussed is the one that has the greatest social importance, the one most closely connected with the question of social stability.

We all crave quick and sure remedies for our troubles; the great sales of patent medicines bear witness to this craving. So, with the maladies of the body politic, we wish a definite diagnosis and a specific remedy. Matters, however, are not so simple. The mother brings her child for examination on account of a single symptom, but to understand the symptom one may need to study the whole child; one may even have to study the parents and the home atmosphere and, instead of giving the mother the desired bottle, one may have to explain to her the relation of the symptom to a complicated social situation. Whether or not she will utilize this explanation will depend upon many factors.

A school system that takes stock of the minor ailments and nervous disorders of the children, and follows the children from the school clinic into the home by means of nurses or visiting teachers, can exercise a remarkable influence on the mental hygiene of these homes. For the adult, the only analogous situation would be that in which the industrial clinic, aware of the importance of mental factors, developed its social work in the same way. To understand the symptoms of the industrial worker, it may be necessary to consider, not only the usual facts dealt with in industrial hygiene, but also the amount of satisfaction got out of work, the atmosphere of the home, the opportunities supplied by the general social environment for healthy social intercourse and for intellectual and æsthetic enjoyment. The industrial clinic, if interested in mental hygiene, might exercise a social influence comparable to that of the school. Unfortunately the worker is on the defensive, suspects exploitation, resents interference; some day perhaps the industrial workers themselves will take the lead in encouraging the study of the conditions of mental health in the industrial worker and in constructive suggestions as to social arrangements.

Summary

The mental health of the industrial worker depends upon the complicated interplay of the individual personality, the specific conditions of the industrial task, the economic factor, the domestic and general social environment.

When dealing with the disorders of the individual worker and of groups of workers, it is not always possible to isolate single symptoms and supply specific remedies, medical or social; and one must be prepared to make a very detailed analysis, and the remedies may be of slow evolution.

So far there is not available enough well studied material for useful constructive suggestions to be made; to gather such material is a task of immediate importance.

The development of an enlightened public opinion on these topics would be a most important contribution to the mental health of the community and to social and economic stability.

The attention paid during war time to the mental health and morale of those engaged in the business of destruction is no less necessary during peace time for purposes of construction; mental health and good morale are as important in peace as in war, and to muddle along in peace may be as disastrous as to do so in war.

HAS MENTAL HYGIENE A PRACTICAL USE IN INDUSTRY?*

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THE president of a company operating a group of industrial plants has become acquainted with rather startling facts put forward by those who have been specially interested in studying defective children, and who have extended their special psychological tests to the study of mental defects in adults. The figures given by these authorities seem to conflict with common sense. He has seen the assertion that one million, seven hundred thousand drafted men were given psychological tests during the war. Seventy per cent of these proved to have reached an intelligence age of no more than fourteen years. Forty-five per cent of the total number were "morons"—that is, of so low intellectual capacity as not to be capable of complete self-guidance.

Our president also has read the review of a book called *Human Efficiency and Levels of Intelligence,* by H. H. Goddard, and notes that the author, working on the assumption that the army was a fair cross section and a large enough sample of our population, has applied the army results to our whole people. Goddard asserts that seventy million Americans are no more than fourteen years old in intelligence. He further considers the facts in relation to industry and makes the point that the inefficiency of large numbers of workers is probably due to their being assigned to tasks that they can never learn to perform well.

In addition, Goddard seeks to substantiate by figures his contention that the low intelligence found in the army is seen also in the general population, as evidenced by the number who "finish school" at an early age, and, in industry, as evi-

* Read at the Annual Conference of the Massachusetts Society for Mental Hygiene on the Human Element in Industry, April 7, 1921. Other papers in this symposium were *Mental Hygiene in Industry,* by Dr. C. Macfie Campbell (see page 468) and *Industrial Hygiene,* by Dr. Wade Wright (see page 497).

denced by earning power. Thus, in the accompanying table,[1] which shows the earnings of groups of wage earners, and compares the age at which various groups leave school with the mental ages of the various groups of soldiers, we see that 68 per cent of wage earners make less than fifteen dollars a week, and 67 per cent of school children do not finish the eighth grade, or grammar school, which corresponds to the 70 per cent of soldiers who are below fifteen years in mental age.

WAGES

Of 100 wage earners

9%	earn	$150 — $200 per year
12"	earn	250 — 300 per year
16"	earn	350 — 400 per year
31"	earn	450 — 600 per year
27"	earn	750 — 1,000 per year
3"	earn	$1,200 per year
2"	earn	over $1,250 per year

SCHOOL

Of 100 children

13%	leave in	4th	grade, age	10
13"	leave in	5th	grade, age	11
14"	leave in	6th	grade, age	12
27"	leave in	7th and 8th	grade, age	13, 14
23"	leave	after 8th	grade	
10"		attend high school		
1.5%		graduate from high school		
3"		attend college		

INTELLIGENCE

Of 1,700,000 soldiers

10 %	in "D—"	Group, mental age 10	Morons able to
15 "	in "D"	Group, mental age 11	contribute to support
20 "	in "C—"	Group, mental age 12	
25 "	in "C"	Group, mental age 13, 14	
16.5"	in "C+"	Group, mental age 15	
9 "	in "B"	Group, mental age 16, 17	
4.5"	in "A"	Group, mental age 18, 19	

Let us suppose that one more thought has come to the attention of our president. He has heard Carleton Parker quoted as saying, "Modern labor unrest has a basis more

[1] After Goddard. See *Human Efficiency and Levels of Intelligence.* Princeton: Princeton University Press, 1920. p. 114.

psychopathological than psychological, and it seems accurate to describe modern industry as mentally unsanitary." He may even have heard that the late Dr. E. E. Southard, while head of the Boston Psychopathic Hospital, expressed the opinion that strikes and other forms of labor unrest may be stirred up by leaders of abnormal mental make-up, agitating among workers whose emotions are sick or whose intelligence is feeble, and that the cure for industrial discord lies as much in the field of mental hygiene as in the field of economics.

Our president is a canny soul. He suspects the accent of propaganda in such large generalizations. He realizes that even scientists will overstate the probabilities of results in a new field before they have become completely familiar with it and its special conditions. He ridicules the Southard theory by saying that if it be true, then all he will have to do to settle the labor problem is to hire a few doctors from the state hospitals for mental disease and make foremen of them. And yet can he be blamed for thinking that some such absurd inference is to be drawn from the generalization referred to?

Let us assume, however, that our president overcomes his first suspicion of all propaganda and decides to make some cautious inquiries. He may feel that nuggets of valuable truth are to be found even in extreme statements. He therefore asks his personnel or service adviser to look into the question and report at the end of a week. "I'd like to know," he says, "just what there is in all this stuff about mental hygiene."

It is from the naïve point of view of such an inquiry that the present paper is written. The writer is not a psychologist or a physician. He is just an employment manager, interviewing the psychiatrist who states that he, from his studies of human nature, can contribute some facts of interest to the employer. He treats this psychiatrist as he would a man applying for a job in industry. This paper does not reveal the results of any original research or indulge in any new inferences for the sake of propaganda. It is rather the sort of critical examination that must precede and accompany both research and propaganda. Furthermore, the paper has to be so brief that the process of development of all the ideas cannot be traced, but only the final steps are given.

At the start it seems necessary to give a few definitions. The layman is likely to confuse similar terms of quite dissimilar meaning—for instance, psychology and psychiatry, which he hears mentioned as different methods of examination into mental conditions.

Psychology is an offshoot of philosophy. In theory, it recognizes that the emotions and temperament have as important a place in personality as intelligence. In practice, whether in the army or in industry, it deals only with intelligence and skill. It is concerned with capacity, and arrives at its conclusions on the basis either of laboratory examinations with strange bits of apparatus or of classroom tests with written answers to standard questions.

Psychiatry is a medical science. It may utilize the results obtained by the psychologist as the basis for determining intelligence levels, but it is much more interested in the emotional and temperamental factors in mental states. It prefers to judge people by their actions in their usual environment, rather than by their reactions to a test. It, therefore, studies their workmanship, their home conditions, and their educational and job history. If their actions and accomplishments are normal, it leaves them alone; if abnormal, it wants a physical as well as a mental examination. What I believe that I am dealing with is psychiatry, largely, and to some extent psychology.

As for what is discovered by mental inquiry, there needs to be a clearer distinction in the public mind between feeblemindedness and mental disease. Physicians may be surprised to be told that intelligent laymen often confuse the two things. It seems necessary, therefore, to point out that feeblemindedness is a limitation of mental ability, either inherited or acquired at an early age. Although feeblemindedness may be accompanied by or caused by mental disease, a feebleminded person is usually sane and dependable in affairs that make no call upon thinking beyond his intelligence. Mental disease, on the other hand, may afflict people of brilliant capacity and may be physical (involving brain decay or nervous troubles) or merely psychological (involving disordered ideas and emotions). Especially it should be pointed out that neither feeblemindedness nor mental disease is an

absolute, but is always a relative term. One person has more brains than another, and one person has more judgment than another. The psychiatrist is interested in mental inefficiencies or psychopathic states which are no more serious or uncommon in the mental sphere than colds and headaches are in the physical. Only, he recognizes that these mild troubles which afflict each and every one of us make us more unpopular or unhappy than physical ills.

It may be well at this stage to make clear what is meant by the term "mental hygiene" which will be used throughout this article. Mental hygiene embraces our knowledge of the laws of mental health, of the personal and environmental conditions that interfere with mental health, and of those mental habits and social influences which promote the mental health of the community.

It is important to emphasize the distinction between the modern medical and the purely spiritual approach to the problem of mental health. Too long did the medical profession insist upon treating the human mind as merely a brain, and refuse to consider any condition of mind not involving physiological change. The medical profession itself has been largely responsible for the vicious misconceptions clustering around the term "insanity." That term marks chiefly a legal distinction between people who are and people who are not responsible for crime. It is supposed to segregate "nuts" from all the rest of us. Those of us who are not "nuts" are assumed to be mentally sound. Legally, we are either sane or insane, just as we are either male or female. I need not stop to point out the many ways in which a new conception of relative mental capacities has been creeping into our criminology—particularly in the handling of juvenile delinquency, in the extension of the idea of the indeterminate sentence, and in such measures as vocational training in prisons. The public confusion on the subject of the insanity defense in murder trials indicates a weakening of the old distinction between sane and insane in law. Nevertheless, there it stands, a false conception, largely unshaken, and a legacy of the old corporeal medicine. The neglect of the mind by those in the best position to study its relation to the brain gave full liberty of action to those whose type of training compelled

them to leave the brain out of their thories. Thus, the Christian Scientists and the Emanuelists have approached mental health from the spiritual side almost wholly, and have given a big start to the study of mental hygiene from the subjective and somewhat introspective angle. Modern medicine, however, has at last waked up and demanded a share in the field that it might have preëmpted. The modern medical approach to mental health no longer leaves the spiritual and subconscious aspects of the mind out of account, and even consents to use the results achieved by the spiritual workers. But it also insists upon relating the brain and the body and the physical environment to the problem. Furthermore, while it does not condemn the method of the psychological workers, it prefers, whenever possible, to continue in the method which it has found useful in diagnosing and treating diseases of the body. If subjective tests yield anything of interest, it wishes to confirm these findings by objective study of symptoms and behavior, under observation within predetermined conditions. This medical approach is the method of psychiatry; and when I consider the problem of the place of mental hygiene in industry, it is precisely this method I have in mind. It is the only method that resembles the manner of meeting and overcoming problems in industry. We do not look for improvements in industry chiefly to those who examine only their own minds and desires for theories of change. By the same token, we should not look for true mental science to those who do not relate the mind to its determining environment.

Having narrowed our inquiry by definition to a question as to the place in industry of the medical approach to mental hygiene, let us next see what a genuine practitioner in this field would like to do, if he had his way with industry. Dr. Stanley Cobb, who teaches the subject at the Harvard Medical School, has written a paper entitled, *Applications of Psychiatry to Industrial Hygiene*,[1] in which he has stated the aim of psychiatry in a way that all psychiatrists would probably be willing to accept. "As conditions are at present," he

[1] See *The Journal of Industrial Hygiene*. Vol. I, pp. 343-47, November, 1919.

says, "a reasonable application of psychiatry to industry would seem to be the following:

"1. Physical examination of all applicants for work.
"2. Mental examination by (a) a period of training and observation, or (b) through mental tests.
"3. Keeping in personal touch with employees' individual problems by means of (a) good foremen, (b) a system for watching individual efficiency, or (c) a sympathetic staff with a psychiatric point of view in the employment-management office, thus salvaging the men who might otherwise be fired.
"4. Training the industrial physician to a knowledge of how human nature is constituted, not in conventional terms, but in the light of a dynamic and living psychology."

Even from the point of view of one wholly unfamiliar with the subject, Dr. Cobb's program does not sound extreme, and it has some inherently attractive features. Nevertheless, it would involve a degree of attention to mental problems which industry is not now giving, and it would assume that the industrial physician had, during his medical curriculum, got some insight into the fundamental factors involved in mental disorder and defect, or it would necessitate the industrial physician's spending a brief period in study in connection with some psychiatric clinic, in order to perform his work more adequately.

Now we are supposed to be asking ourselves just how far industry would consider these things to be practical. But perhaps it would be well first to ask if there are any obstacles to our doing them, even if they were practical. We know that there are many things that we could do and perhaps ought to be doing, but that, because of some obstacle, we are not doing. The religious issue, for instance, is an obstacle in the way of a practical solution of the Irish question. Opinions about President Wilson created an obstacle to the practical solution of the peace question. I think that there are obstacles to the early adoption of psychiatry in industry.

First of all, physicians, as at present trained, have an

extremely meager knowledge of psychiatry, and unless they have spent some time after graduation in specializing in this branch of medicine, they are not in a position to deal adequately with the problem of mental hygiene in industry. It is, therefore, certain that at the present moment there is no adequate medical personnel with psychiatric training to place at the disposal of large industrial organizations, should they desire such coöperation. The universities have become aware of this deficiency and are doing what they can to improve the situation, but progress in medical education is necessarily slow, and it will be many years before industry can expect to find among the medical profession the necessary number of physicians competent to deal with these problems.

A well-known employment manager of my acquaintance writes me that she considered last year engaging a psychiatrist, but was scared off because those she interviewed wished to subject all employees to a mental third degree. She felt that, what with physical examinations and centralized discipline, the workers were submitting to just about enough already.

Another factor to keep in mind is the necessity of extremely tactful introduction into the industrial relations of any type of examination that seems to be too intrusive or to suggest personal disqualifications, with regard to which an individual is apt to be extremely sensitive. In this connection, tact is of supreme importance. Any one will chatter, if not boast, about his symptoms of Bright's disease; and if, perchance, he has been operated upon—had his stomach removed and his duodenum sewed on to the esophagus—he takes a childish delight in talking about it. But where is the man who will admit that he is not as bright as he might be? No one likes to discuss his mental failings, precisely because of the common impression I have before mentioned—that a man is either sane or insane. This brings it about that any inquiry into a man's degree of mental efficiency is construed as a doubt of his sanity. But that is not the whole source of the difficulty. The special sensitiveness about mental diagnosis is due also to the fact that our minds are so much more *us* than our bodies. Those who believe in personal immortality dispute as to whether the body will be resurrected, but none doubt

that the mind is immortal. To suffer loss in a member of the body is no more serious than forgetting a part of our past experience; but touch the vital core of all our life—our sound and self-disposing mind itself—and you do us more serious injury than in paralyzing our whole body.

Perhaps a third difficulty consists in the fact that emphasis on the conditions of mental health tends to suggest a new philosophy of life, a new attitude towards social discipline and control.

If it is true that people vary in mental capacity and mental health, and that each different degree of capacity involves a different degree of power, of judgment, and of corrective behavior, then it is also true that people vary in degree of moral accountability. The old definition of sanity was "ability to distinguish right from wrong." Those who were sane were held accountable for their acts and punished when they did wrong. The psychiatrist points out, however, that perception of moral and ethical questions varies according to the individual, and that waiting for wrong to be committed and then punishing it is wasteful and ineffectual. He proposes, instead, an adjustment of society and industry in which a man's competence to act will be tested, and his freedom of choice restricted to those fields in which he is capable of acting correctly.

Now this, if carried out to its logical conclusion, would involve a very saddening restriction of the freedom of the will and of liberty of action. The old theory of strict accountability was so much more tonic. It was too bad to see any one go to hell because he willfully lacked judgment, but it was a great game to be free to go wrong at any time. It was thrilling to fight the great fight twixt Good and Evil every day. Even if you didn't know which side you were fighting on, it was a great fight anyway.

I feel very sure that people who resist prohibition, people who oppose sterilization of criminals and feebleminded, people who set up a particular theological formula as a guide to all right conduct, will resist the theory of limited accountability. It is not merely a misconception they will have to get over, but their whole philosophy of life.

Perhaps I dwell too long upon obstacles. But part of the

discussion can be credited to consideration of how to overcome them. In the psychiatrists' method, if I understand it, a complete examination of erroneous ideas is part of their cure. To recognize prejudice as prejudice is to go a long way toward dispelling it.

The obstacles can be overcome sufficiently for psychiatry to make its way. Truth can advance through and around error. We can have gradual immunization against smallpox even in a state where the legislature surrenders the public right to protection by vaccination, and these difficulties in the way of psychiatry will probably all be met. In the first place, the psychiatrists will be less queer when it seems less queer to be a psychiatrist. The present group constitute a kind of volunteer poison squad who taste the new doctrines as an encouragement to the more conservative. Again, a tactful education of the public on the subject of relative mental conditions will make study of mental efficiency seem less awful. And the way to make the extension of psychiatry to the great mass of ordinary people seem less of an insult is, precisely, to extend it. Until these obstacles are overcome, however, I do not look for a very widespread and public use of psychiatry in industry.

Must psychiatry wait, then? We shall all be dead before prejudice dies. Fortunately for progress, a novelty does not have to wait until it can be widespread and self-asserting before it can get a foothold. Novelties have to make a piecemeal conquest. Samuel McChord Crothers, in an illuminating essay entitled, *Protective Coloring in Education,* has pointed out how every new truth has come in under the cloak and favor of an older and more acceptable doctrine. When theology was master of logic, science had to present itself as an interpretation of the gospels. Hugh Miller's original book on geology purported to be an explanation of the first chapters of Genesis. Paley's studies of anatomy and physiology were offered under the title of *Natural Theology.* At another time, when polite literature was the more respectable, Charles Darwin's grandfather published a treatise on botany in the form of an allegorical poem, entitled, *The Loves of the Plants,* in which the real information was conveyed chiefly in the footnotes.

I am inclined to think that a subject which has to meet so much ignorant prejudice as psychiatry will also have to adopt

some protective coloring. I think I can point out, indeed, that some phases of the subject are already developing in industry without any one's suspecting it.

In the first place, consider the gradual adoption of the idea that there is such a thing as a varying degree of intelligence or mental capacity. Recently, in the clothing trade in Baltimore, the unions themselves agreed to a grading of workers according to ability, A, B, and C, and consented to varying rates of compensation in each grade. Management has long contended that there are differences between workers, not only of temperaments and bents, but also of capacity in general. For this reason, partly, it has rejected the idea of a straight day wage, and insisted upon payment according to output. Lately it has gone further and begun to rate workers according to intelligence and other qualities as a basis for assignment and promotion. Armour & Company, the Westinghouse Companies, the General Electric Company, and Sears Roebuck are among the well-known concerns doing this. It is true that such ratings are made upon the basis of the uninstructed opinions of superiors, and not on a psychiatric or other presumably scientific basis, but the idea of relative mental capacity is certainly implied in the proceeding.

Correlative to such rating schemes has been a corresponding development of the idea of "job specifications." Nearly every modern employment department has made, or is making, a set of job specifications. These are standard descriptions of mechanical operations, together with a specification of the type of worker needed in each case to perform them. Not only the degree of physical strength and skill, but also the degree of mental capacity, is usually prescribed. The assumption is, of course, that different applicants will be found to possess a varying and measurable degree of native intelligence. Perhaps it also implies that it is wasteful either to put a man on a job for which he is not competent or to squander a brilliant worker upon a job beneath his qualities.

The discovery has even been made by industry that there are feebleminded people, and that some jobs thrive in the hands of the mentally deficient. A well-known button factory has certain monotonous inspection operations to which it assigns feebleminded workers of tested and guaranteed in-

capacity. Dr. Bernstein, of the Rome State Custodial School, placed out for day's work one hundred feebleminded girls, all but two of whom made good. I have good reason to believe, as you will presently see, that a good many workers who are satisfactorily filling their jobs are really of less than average intelligence, but are under no stigma of feeblemindedness, because their jobs make faint demands upon the intellect.

There may be some who will be surprised to hear that I consider that the whole employment-management movement, which has made itself at home in industry during the last decade, is guided by the point of view of mental hygiene. Its purpose is identical—to substitute for the old policy of hire and fire a more subtle policy of individual adjustment. The policy of transferring from job to job—seen at its extreme with the Ford Motor Company, which will fire nobody, but shifts incapabilities till they find a proper niche—is a recognition of the existence of different levels of intelligence and mental condition. The idea of physical examinations as a foundation for correct physical adjustment, the study of illumination, posture, and fatigue, the establishment of rest periods, the organization of recreation and social activities, and the provision of good restaurant and sanitary facilities, all recognize that health and happiness condition not alone industrial peace, but mental efficiency. These things are not usually called mental hygiene, because of the common misconception of mental hygiene as a subject dealing only with crazy people. But those who know that discontent and unhappiness are the first stages of mental disease realize the import of these measures.

The most outstanding example of mental hygiene in industry was the work during the war of Colonel Brice Disque with the loggers of the Northwest. For years the lumber industry had been a plague spot—a hotbed of I. W. W. outlawry. Carleton Parker diagnosed the trouble as industrial insanity. He said that the loggers were "voteless, womanless, jobless," mentally sick vagrants who were crazy because they lacked decent bosses, comfortable huts, warm blankets, good food, and steady work. Above all, they wanted to have their manhood recognized. They were mostly men who

thought with their emotions, and their thoughts were wild because their souls were sick.

The employers never believed him, but when the war made the government interested in spruce, it found that it had to get interested in men. Some inspired intellect in the War Department put Colonel Brice Disque on the job of logging for men. Where did they find him? Running the state prison in Michigan, treating his criminals as so many children or sick people, and they had the courage to put him on the industrial job.

I have no space to tell of the magic wrought by Disque. He made his job a straight-out enterprise of mental hygiene. Not that he examined and diagnosed individuals and gave them pretty thoughts to hold, but that he gave them handsome things to think about—steady work, decent conditions, and democratic self-expression. And the result was that the disloyal I. W. W. became the Loyal Legion, and got out the timber.

Such an example as this makes it easy to see that mental hygiene has a place in industry and is often found there. Colonel Disque's work was a good example of the application of the principles of mental hygiene. Its diagnosis was based upon intuitive recognition, rather than upon scientific scales of values and methods of inquiry. Its treatment was general and wholesale, like a job of public-health work. The psychiatrist points out that general causes make a whole group of people ill, but that special causes, even in a healthy community, make individuals ill. Disease has to be fought both wholesale and retail. You quarantine and vaccinate and clean up to prevent the community from contaminating the healthy individual, and you cure the morbid individual to prevent his infecting the community.

I think we may safely say that modern industry has begun to appreciate that mental conditions have to be studied and psychological remedies employed. No very definite technique is employed. Workers are divided into classes without being accurately classified; mental troubles are doped without being particularly diagnosed. Either the work is wholesale or wholesale generalizations are applied to individuals.

This may be enough. Industry always has an argument

against any new proposal in the statement that "it has somehow worried along without this thing so far, and might as well continue to do so." Even if it is true that 45 per cent of the people are morons, no more than twelve years old mentally, what of it? The textile industry used to work children five and six years old. We have in our own mills some old-time workers who began at the age of nine. Their tasks have not changed since, and it is their own affair if they have themselves grown any since. It is only recently that a federal law kept children out of the mills till they were sixteen. The great majority of industrial tasks don't require good minds, but good habits. Why bother about mentality?

Mental hygiene has a reply to this. It tells industry: item one, that the reason the government raised the age limit for child workers was because, even if industry could use workers only nine years old, the state couldn't use voters so immature. It tells industry: item two, that a nine-year-old intelligence can't hold sway over emotions and instincts and a will that may keep on growing to the age of fifty. It tells industry: item three, that most of our crime, drunkenness, and inefficiency is due to the mistake of letting persons with adult impulses and childish intelligences operate without guidance. Mental hygiene in industry, therefore, would not throw out the 45 per cent of morons, but it would throw around them the protecting arm of science.

The very reticent and cautious medical director of the Massachusetts Society for Mental Hygiene—Dr. A. Warren Stearns—has done a fine piece of work to which he has given no publicity. I cite it for its moderation as an illustration of how carefully the true scientist would take up work in industry, even if he were given freedom of action. During the war, Dr. Stearns made psychiatric examinations of some thirty thousand naval recruits at Mare Island. The great mass of them never saw Dr. Stearns. They had filled out cards, similar to applications for employment, on which they gave some details about jobs they had held, schools they had attended, and family relationships. This information, which is called "social history," passed through Dr. Stearns' hands. In most of them he could read normal adjustment to life, and the writers were not interviewed. In some 10 per

cent, he thought he saw incapacity to make adjustments easily. These men were tactfully questioned, and a little less than a third of them proved to be unfit for the navy. The remainder were scheduled for further observation, or better assignment, or close supervision. Two or 3 per cent of mental incompetents isn't a large one to make a fuss about, yet any one defective might have lost a submarine or caused an explosion in the boiler room.

Recently I attempted to apply Dr. Stearns' principle of selective inquiry to a group of three hundred employees in an industrial plant. The study was made for me by the employment manager, the plant manager, the plant physician, and the nurse, under the guidance of a graduate student of psychology and mental hygiene. Using the employees' records as social histories, they selected a certain number as probably deficient or probably somewhat deranged. Of these, only twelve seemed to the executives, who knew them, to warrant further study. These twelve were observed, considered with regard to production, conduct, and family relationships, and reviewed in the light of their physical examinations. Ten were classified as probably deficient, but only one as actually feebleminded. Several of these were simply cases of senile decay. Two only were regarded as persons needing treatment for abnormal mental conditions, and only one was recommended for study at the Psychopathic Hospital. Of the whole twelve, five were rated as "very good" in their work, five as "good," and two as "fair." Apparently the assignment of workers in that plant is so good that very few are set at tasks beyond their intelligence. It might, of course, reveal a poor standard of rating workers, when low-grade minds are rated "very good." It is more likely to reveal, however, the ease with which places can be found for the person of tepid intellect.

It would be unwise, however, to assume, because the low intelligence of these people did not affect their rating, that it did not affect their competence as citizens, as members of an industrial organization, and as parents of other industrial workers. To detect feebleminded or deranged workers whenever it can be done, as it was in this case, without disturbing the equanimity even of the suspected ones, seems to me to be

decidedly worth while as a guide to physicians and employment managers in their work.

Mental disease is curable, but feeblemindedness is as incurable as big ears. As Professor Goddard phrases it, "every human being reaches at some time a level of intelligence beyond which he never goes; these levels range from the lowest, or idiotic, to the highest level of genius. The number of people of relatively low intelligence is vastly greater than is generally appreciated, and this mass of low-level intelligence is an enormous menace to democracy unless it is recognized and properly treated. The social efficiency of a group of human beings depends upon recognizing the mental limitations of each one, and so organizing society that each person has work to do that is within his mental capacity and at the same time calls for all the ability that he possesses."

Thus the hygiene of dealing with the weak-minded in industry would differ radically from the hygiene of dealing with the mentally sick. The former cannot be educated beyond their intelligence—but they can be fitted to appropriate work and trained in good habits and kept physically fit so that they do not deteriorate to a still lower level. It seems to me that even if the morons of industry do not lower the efficiency of operation, it is nevertheless valuable to tag them, if only to spare us the trouble of trying to force them beyond their capacity.

That part of mental hygiene which deals with the mentally disordered, however, is more difficult, precisely because a cure is usually possible. It is more closely relatable to efficiency because it leads to absenteeism, conscious withholding of efficiency, dishonesty, fights, turnover of labor, strikes, etc. And it is hardly necessary to adduce proof that these inefficient occurrences are frequently due to mental disorders. We have only to broaden our definition of a mental disorder to include the state of mind that produces these things. No one doubts the necessity of studying human motives and instincts to find the key to conduct. There can be no debate, therefore, over the desirability of employing psychiatry to cure mental disturbances, once we admit that psychiatry is the best collected, classified, and tested knowledge about

human motives and instincts in disorder. Indeed the hard-headed manager who boggles at the idea of examining his workers to see if there are any "nuts" among them is likely to welcome psychiatry with open arms once he learns that it is concerned with mere trouble makers. Any one who wants to deal with "grouches" and "kickers" and chronic absentees is welcome to his work, even if he does like to regard these disagreeable folk as merely sick minds.

As an employment manager reviewing the question of the practical application of the principles of mental hygiene in industry, I offer the following suggestions: First, that we consider for the present only the modern medical approach to the subject; second, that we strive to clear up misconceptions on the subject of mental hygiene; third, that we recognize wherein we are already employing mental hygiene in industry; and finally that we make a cautious approach toward a more scientific and technical direction of the work we are already doing. The caution is needed not only because we lack experience to guide us, and lack even an adequate body of medical specialists, but also, especially, because the education of the public takes time, and prejudices die hard.

As I view it, this cautious approach would be quite in line with what Dr. Cobb advocated. Obviously, the first step is further enlightenment of the employment managers and physicians already doing a general sort of mental-hygiene work in industry. To this end I suggest conferences of such workers at which papers on the subject are read, if possible by psychiatrists. When these workers are informed, an effort should be made to clarify the minds of general executives on the subject, so that any later steps can be taken with proper assent. Perhaps it will then be possible to make a mental-hygiene survey of an industry. Such a survey would be a study of both the conditions affecting the mental attitude of the workers and an examination of social histories as shown on the records. Only rarely would individual personal examinations be necessary. These would be conducted so as not to indicate doubt of the employee's sanity, and perhaps would be incidental to an interview brought about ostensibly for some other purpose.

Such a survey would then be used as a basis for further

study and training or action by the regularly employed service workers. The professional psychiatrist would need to come in only as a consultant and trainer for the other personnel workers. The great advantage of utilizing the regular physician and service workers, instead of a psychiatrist, lies in the fact that inquiries by the former start with the assumption that the subject is normal, whereas questions by the latter seem to imply the reverse. The advantage of having an open-minded, willing subject instead of a rebellious or frightened one, is obvious. The possibility, too, of organized protest against even the most innocent and sympathetic attempt at mental hygiene is clear.

With all due cautions, however, and with all acknowledgements to the present state of the public understanding of the subject, mental hygiene has, in my opinion, a real and important place in industry and offers great promise of public service.

INDUSTRIAL HYGIENE*

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MOST people wish health, and most people do not have it. We have not developed as yet any mechanism by which the disabilities of the sick may be early remedied. We cannot tell for any large group of our population what the extent of sickness is or accurately assign causes for the burden of lost health and usefulness.

Industrial hygiene is the hygiene of the workers in industry; it is concerned with the health of forty millions and more of our people. It is involved only incidentally with the problems of specific industrial disease. It is not so much a thing of itself as it is a way of doing a thing, a way of combating the public ill health, using industrial life as the field of encounter. It carries the art and science of medicine to a great group rather than awaiting the late coming of that group to medicine.

Employers and employees have been given to protesting that personal sickness was a responsibility, even a privilege, of the individual, solely his own concern. It could be that only for an individual who had no place in any social order. It is no longer the height of good form to enjoy poor health.

Statistical evidence regarding the frequency of industrial accidents is staggering. The time loss to workers and their fellows is an impressive and costly total. The loss due to sickness, however, is in the aggregate vastly greater—in many instances five to ten times as great.

It is not the sick man alone who pays—we all pay.

Of non-disabling sickness we can only roughly reckon the extent of severity. Recent studies of the Harvard Mercantile Health Office show that in a number of store dispensaries 60

* Read at the Annual Conference of the Massachusetts Society for Mental Hygiene on the Human Element in Industry, April 7, 1921. Other papers in this symposium were *Mental Hygiene in Industry*, by Dr. C. Macfie Campbell (see page 468) and *Has Mental Hygiene a Practical Use in Industry?* by Boyd Fisher (see page 479).

per cent and more of the store personnel make use of the dispensary each month. This finding suggests the incidence of minor ailments among the populace at large, much of it not as physically fit as the portion in active work.

All of the disabilities of man are not physical, and the mental disabilities must be of great concern to the worker for industrial health. One cannot consider the findings of the army psychiatrists that 70 per cent of almost two million men had a mental age of less than fifteen years, even discounting it generously, without realizing that handicapped minds, like sick bodies, cause industrial wastage and a vast amount of sorrow and discontent.

Little is known of ways to develop medical service in industry, but less is known of industrial psychiatry. For the psychiatrist there is a splendid job. It promises much in the way of aid in the difficult task of fitting men to the jobs they can best do and jobs to the men they need. Even with such an adjustment consummated, industrial discontent will still be found—but it should be a healthier unrest than we now know and that day a better one than this.

THE MENTAL HYGIENE ASPECTS OF ILLEGITIMACY

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IN the mental-hygiene approach to the problems of an individual or of society, we aim to discover the motive that lies behind every act and to recognize the elements in the personality of the individual that, influencing his attempts at adaptation, modify his behavior. At the same time we recognize that a method of adaptation may possibly symbolize something quite foreign to the act itself. It is absurd to accept the concept of mental hygiene as synonymous with mental pathology, for, indeed, many aspects of the situations that come under observation in the study of conduct constitute essentially normal adaptations. In order fully to appreciate this fact, it is necessary to stress the possibility of discovering in every situation factors that offer an opportunity for successful management and for formulating a constructive program. Thus, in the study of the problem of unmarried mothers, it is pertinent to ask: "What is it, besides the actual sex experience, that leads the girl to indulge in illicit sex relations, and what is it that she seeks in choosing this method of expression?"

To answer this question, it is necessary to distinguish between illicit sex relations as such and sex promiscuity constituting a behavior tendency. The mere fact that a girl has engaged in illicit sex relationships does not justify the assumption that of necessity there need be any pathological mental situation involved. The impression gained that such is always the case in antisocial situations is due, of course, to the fact that we have hitherto had an opportunity to study only highly selected groups of sex delinquents. These girls have come under our care as a result of the necessity for assistance on the part of the community. In these cases we see another factor entering which we must recognize as that of social maladjustment plus illicit sex relations. While we may be justified, therefore, from the study of data obtained in insti-

tutions and clinics, in saying that there appears to exist an important correlation between illicit sex practices and mental pathology, it would be folly to generalize and assert that this correlation is indicative that a definite relationship exists in all cases between illicit sex practice and mental pathology. Until such studies are made among diversified groups and in all strata of society, we have no true criteria for judgment. We know—possibly to some degree theoretically—that the problem of sex and sex expression is not confined to the particular group of persons whom we have been permitted to study in the past, but that it exists in every walk of life. The sooner we are willing to accept the fact that sex and sex relationships constitute a practical problem for all of us, the sooner shall we be able satisfactorily to comprehend and intelligently to handle the problem in others.

For the purposes of this discussion, let us leave out of consideration at present those individuals who fall into the first group, in which we have a combination of definite mental pathology and sex promiscuity and probably a definite and important relation between them.

In another group we may include those individuals in whom illicit or promiscuous sex expression exists as a definite behavior tendency. Here this behavior tendency in itself is often so unusual as to justify inquiry into its nature and causes, and, if we are to accept responsibility for management, it should be our concern to ascertain every possible means of satisfactory adjustment. In speaking of mental hygiene in its relation to illegitimacy, this is the most important group for consideration. How, then, may we define this type of behavior from the mental-hygiene point of view?

If we can for the moment rid ourselves of a strong inclination to consider this problem from an ethical point of view, and regard it as a problem of behavior, we will find that it is necessary to apply the same criteria that we habitually use in the estimation of any other kind of a behavior problem. Thus we are justified in assuming, on the one hand, that there may be conditions in which a pathological state of sex equipment exists—that is to say, an undue and disproportionate urge for actual sex expression—while, on the other hand, we may have a girl with essentially normal sex equipment in

whom there is a lack of ordinary inhibitions, for we must accept the fact that most individuals possess sufficient inhibitory powers to assure proper adaptations with reference to their sex lives. We know that there are individuals in the former group who are naturally excessively equipped sexually. We have definite physiological proof that there may exist certain misdevelopments or misfunctionings of the internal glandular system of the individual which result in a precocious sex development and, accompanying it, an undue intensity in the sex requirement. Here, of course, the situation is relatively simple in its explanation if not in its management, for it can be looked upon from a purely medical point of view.

One's intense sex cravings may not depend upon these purely physiological difficulties, however, but may arise from the use of one's sex equipment in an effort to overcome certain thwartings of activities in other directions. Because of an abnormal conditioning influence in the sex development of the individual, either sex control or normal sex expression may be made difficult, if not impossible. It may be the case that, as far as an individual is concerned, illicit or promiscuous sex life is the only kind of sex that can be indulged in with any degree of satisfaction.

For example, consider a girl in a family with a number of other sisters. An older sister may throughout this individual's memory have received more attention, more thoughtful care, more opportunities for social adulation, more attractive clothes, and more recreational outlets, while younger sisters, because they may serve mother and father as outlets for instinctive parental cravings, may be objects of envy. Soon we may have such a girl thinking that she is not as desirable as her sisters. She may develop a "grudge attitude" and feel that in her experience outside the home an opportunity is presented to obtain compensation for the things which the home fails to supply. When she reaches the age at which she gains renewed impetus for self-expression as a result of the adolescent urges and newly awakened emotional strivings, she will seek an opportunity for social outlet. It is in just such cases that we do find, at times, girls entering into lives of sex promiscuity in a definite attempt to find some

means of compensation for the imagined unjust situation in the home.

The second group includes also the girl who, from early difficulties in making adjustment to the family and social situations, reacts by developing a sense of inferiority. After repeated failure in making adjustments that appear satisfactory to her and finding that in certain instances, in the competition of life as she sees it, she does not measure up to the standard which the other members of the household or the small community in which she lives set for her, instead of accepting her apparent limitations and so organizing her known abilities that she can successfully compete along channels of her choice, she blindly seeks some way of "putting herself across" in the community. If she finds that this can be done through the medium of sex expression, in many instances she accepts this as the most satisfactory means of self-magnification—in other words, she accepts the life of sex promiscuity in a blind attempt to compensate for the things with which life in other phases fails to furnish her.

In the light of the recent knowledge of psychopathology, we cannot fail to recognize that sex factors may enter into the father-daughter and mother-son relationship. Because of a type of pathological attachment to the father, a girl may find, when she expresses her true sexual interests, that all other men are sexually unattractive, and if she permits her feelings free play, may be inclined to submit herself to promiscuity. In a recent report of the Chicago Vice Committee on the study of a group of prostitutes, it was found that about 50 per cent of the girls had been seduced by their fathers or other adult male relatives. Thus such interests on the part of these girls bear directly upon the problem of prostitution. In some instances it may be conceived as a substitutive process and in others possibly as an unconscious protest.

Now let us consider those individuals with assumedly normal sex development who lack the normal inhibitory equipment. We must accept this type as belonging to a group with a definite pathological basis. With this conception we are justified in looking for a pretty definite correlation between feeblemindedness and illicit sex practices, but we must be

cautious about seeing cause-and-effect relationships where perhaps only correlation exists. In the attempt to seek a satisfactory solution of this problem, we should look for a social-environmental situation in which special safeguards may be thrown about such individuals. In other words, feeblemindedness in the problem of unmarried mothers or illegitimacy is largely a matter of maladjustment. We have, for example, the group classified as imbeciles and low-grade morons, who have little more interest in sex matters than children of their corresponding mental age. The problem with such persons consists largely in protecting them from becoming innocent victims of the sex activities of others. The solution of the problem is early recognition and adequate institutional or other supervision of girls who, in unsatisfactory home environments where the moral codes are appreciably low, receive unintelligent treatment and are exposed to all kinds of harmful contacts.

Another group is made up of higher-grade defectives, frequently of attractive physical make-up, who, because of their narrowed general interests, frequently endow their sexual phenomena with added significance. Since sublimational channels are few and unsatisfactory, such girls receive little satisfaction from their meager intellectual endeavors and often voluntarily seek expression for their sexual desires in promiscuous sex relationships, with little or no vision of the responsibility incurred in probable motherhood. In a recent survey of a House of the Good Shepherd, where girls of sixteen and over receive court sentences for periods of six months or a year, I found among the white girls there approximately 43 per cent of feeblemindedness and among the colored group 71 per cent. This is of special significance when, on studying the sentences, more than half were found to have been convicted of prostitution (or "associating with immoral persons," a classification that has less social stigma attached, but means the same thing). It is not conceivable that, at the expiration of their sentences, there will be much appreciable change in the social attitude of these girls and certainly no variation in their original mental endowment. The only satisfactory means of controlling this phase of the problem of illegitimacy will come when the judges accept the significance

of a competent medical diagnosis of mental deficiency and accord a defective girl opportunity for care in an appropriate institution or for adequate community supervision. One is often asked if feeblemindedness carries with it a hyper-sexed state. In some feebleminded individuals we find this to be the case. This, together with the absence of normal inhibitory faculties, tends to create important sex problems.

When we consider the problem of sex control in its widest aspects, we must conclude that only those individuals who are biologically well adjusted, and whose sexual cravings are so conditioned that in their strivings toward gratification the output of energy is normally utilized in the reinforcement of the ego struggle for social esteem, can be considered as possessing the key to satisfactory adjustment. We are, then, led to believe that no individual can have an anxiety neurosis so long as she can maintain her sexual potency without jeopardizing her need for social esteem. If the girl can maintain her sexual potency only at the price of social esteem, she may become a social delinquent. If, on the other hand, sexual potency is sacrificed for the sake of social esteem, an anxiety neurosis may develop unless the sexual striving can be thoroughly sublimated. Thus it is that our problem of education toward a satisfactory social adaptation should begin before the girl has reached the stage of motherhood. Sublimational outlets must be furnished before the damage is already done; this course offers the most effective means for the control of this problem of sex promiscuity.

In the psychoneurotic group, in whom this type of behavior may be a response to undue repressions at various times, promiscuity in sex may be taken as a state of emancipation or freedom from former repressions. The organically or functionally inferior individual must make an adequate compensation that will not only win in competition, but also win the social esteem of her associates. If this cannot be accomplished, there always exists a conscious sense of inferiority. The compensation which the individual must achieve may in some cases show itself in illicit sex practices, for in such practices the individual protects herself with a sense of superiority over her associates, since she can in this way receive more attention from male admirers.

In the sex problems of psychopathic individuals, some of the same principles can be applied, for in the individual's equipment and organization there are often evidences of failure to measure up to the standards conceived by that individual as existing in others.

In the epileptic states we find dissociation of the personality, infantile irresponsibility, poor judgment, and unstable emotional equilibrium—all capable of directing the epileptoid personality into various experiences in which sex factors may be prominent. With such individuals also we may find that attempts at adaptation along socially accepted channels fail, and they, too, find compensation in promiscuous sex indulgence.

Finally, there still remains an apparently large number of normal girls who deliberately accept their sex attributes as a forceful means of putting themselves across in the community. Here, it would seem, lies much of the real problem of illegitimacy and prostitution. We must ask ourselves to what extent society has given its approval to this means of self-expression as an opportunity for gaining esteem in life before we can classify such conduct in any terms suggesting deviation from health.

What is there that mental hygiene can do in a constructive way in dealing with some of the complex problems that have been indicated? The very fact that mental hygiene emphasizes the principle that there is a cause back of every phenomenon in human behavior ought to give the worker in this field a kind of open-mindedness and freedom of action that cannot be the case when the problem is approached with emphasis only on the conventional ethical point of view. Working from the mental-hygiene point of view, one is more likely to take an objective attitude toward the problem, while if it is approached from the other viewpoint, the element of emotion enters into the worker's own examination of the facts so that success is achieved in inverse ratio to the degree of emotion involved. The mental-hygiene approach involves, further, the principle that no phase of the native equipment of man or woman can be managed adequately by mere denial of its existence. The individual must be able to accept himself as he is, recognizing his limitations together with his

assets. In doing so he is obliged to recognize certain urges within himself that must be curbed and controlled. These urges can be handled successfully only when they receive recognition of their existence and are directed into socially acceptable channels. For example, it is pure nonsense to tell a girl that she must not think of sex, must "put it out of her mind" or "forget about it," when a strong tendency within herself draws her attention continually in this direction. What one wants to hold out is the possibility of the management of these urges in a manner acceptable to social dictates. Success in dealing with cases of this type depends largely upon the ability of the worker to explain and to help the individual to make the necessary personal adjustments. We will become more liberal-minded and consequently more effective if we take into account the great number of potent sex forces, and recognize that, while by nature and trend of thought we all are driven in the same direction, through insight into the management of these urges we may discharge troublesome tensions through socially accepted channels. One must go a step further and recognize that there is always the possibility of utilizing this driving force, common to each one of the human race, for the most constructive as well as the most destructive purposes. Often, where this creative force is utilized along destructive channels, it is not so much through mere viciousness or pathological tendencies as through mismanagement and principally lack of insight into the nature of the problem that actually exists. On the other hand, it would be extremely fallacious to assume that a problem is solved merely by gaining insight. The real task for workers in this field is the task of translating "insight into influence." Unfortunately the principles by which one can accomplish this task are far from being fully developed. One of the fundamental requisites for a worker in this field, before she can hope to achieve any satisfactory results, must be a thorough adjustment of her own sex life. It is believed by some psychiatrists that the most satisfactory worker and the one who can bring the most forceful influence to bear upon problems of illegitimacy is the married woman, for to her have been accorded not only an opportunity for a normal and legitimate outlet, but ability to secure and retain an open-

minded, objective attitude. Not all married women have these happy attributes, however. The really essential thing is a satisfactory adjustment of one's own sex life, even after many difficulties, and an objective point of view.

In the satisfactory solution of the problem of the unmarried mother, we must search for the basis of her maladjustment not only through the study of her social and environmental setting, but, most of all, through a careful investigation and study of her personality. This can best be done by an individual with mental-hygiene training. In order to protect the girl from the necessity of numberless interviews and uncomfortable experiences, it would seem expedient in every large community for an organized effort to be made by the agencies in contact with this problem to create a center for a special study of girls under their care, this study to be carried on by a well-organized team of workers, including a psychiatrist, a psychologist, and a psychiatric worker. As a result of the careful studies and the determination of causative factors that could be carried on in such centers, it will often be possible to make more satisfactory classifications and furnish means by which a girl may be aided in understanding her problems, finding satisfactory sublimational outlets, and making more satisfactory social adjustment. We must not lose sight of the fact that in the pregnancy itself we may find a potent factor for good. All women are endowed with a maternal instinct, and as the physiological processes continue during the prenatal period, certain psychological influences are also at work and the maternal desires gradually unfold themselves. If, through our efforts, we furnish this mother with an unstigmatized opportunity to remain with her child, to assume the responsibility of its care, to have a normal outlet for the pent-up love craving, we will discover that much sex hunger can find a normal outlet through the sublimational channels of mother love. This fact should be borne in mind when we consider the problem of child placing, for the normal outlets furnished through motherhood may serve to determine the satisfactory future adjustment of the girl, while, if we ignore this opportunity, she may find no adequate satisfaction except in return to her former illicit sex practices.

It is my purpose merely to urge the importance of seeking

to discover the motive behind every act and to recognize the elements at work in the personality of every individual who comes to attention because of failure in dealing with the problems of life. In such studies, which require what I have termed the "mental-hygiene approach," we may often find the key to the real situation in the problem of the unmarried mother.

THE EDUCATIONAL VALUE OF PSYCHIATRIC SOCIAL WORK*

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AS an organized activity requiring special preparation and known by a name of its own, psychiatric social work has come into existence only within the last five years. Its function in relation to psychiatry has become fairly well defined, but its place among other branches of social work is not yet generally understood, and the lines of its future development are not yet clear. In considering the influence that psychiatric social work may exercise, it is therefore necessary to take account of what it is and what it may become. For its influence we will naturally look among those groups with which its workers are in closest association—physicians, social workers, and the general public.

As an unsystematic endeavor, psychiatric social work is as old as psychiatry, for psychiatrists have always of necessity taken account of social conditions both as cause and effect in the treatment of mental disease and have attempted as far as possible to follow their patients into the community. In many hospitals the need for better facilities for attention to social aspects of the cases was keenly felt years before special provision was made for it. When in time certain hospitals were ready to introduce a social service, they naturally looked for the personnel of this new department among social workers, who had been specially trained to deal with social conditions. The principle of the social service was not merely an extension of the doctor's efforts to deal with social factors, partial and spasmodic of necessity, but an attempt to introduce into the plan for patients' care the point of view and special knowledge and technique of the social worker. The doctor added to his equipment an assistant trained in a special field.

* Read before the Mental Hygiene Section, National Conference of Social Work, Milwaukee, June 28, 1921.

The place of psychiatric social work in the mental hospital or clinic is now well established as an aid in diagnosis, treatment, and research. A committee of psychiatrists and social workers which met last summer under the auspices of the National Committee for Mental Hygiene to consider the function and training of the psychiatric social worker defined her function as follows: (1) to facilitate admission to hospital or clinic and continuance of treatment; (2) to bring to the physician personal and social data helpful in arriving at a diagnosis and in outlining treatment; (3) to assist in carrying out treatment; (4) to interpret hospital and clinic to patient, family, and organizations of the community; (5) to make social investigations contributing to medico-social research.[1] It is evident that with assistance of this kind the psychiatrist has greatly increased his facilities for both the study and the treatment of mental disease.

In relation to social work, the function of the psychiatric social worker has not yet been defined. In discussing this relation, it is first of all necessary to consider the nature of social work. The time is past when social work was conceived of as consisting merely of practical measures for the prevention and relief of distressful situations caused by poverty, sickness, and crime. This is the idea embodied in the old name of the conference—Charities and Corrections, and it went formally out of existence in 1917, when the name was changed to National Conference of Social Work. But social work is still not quite sure of its identity and in any gathering to-day of social workers, teachers in training schools for social work, and professors of sociology, the question never fails to arise: "Is social work really a profession?"

Many persons both in and out of social work believe that there *is* now a profession known by the descriptive term "social work," which is in the early stages of its development, and that this profession calls for specially trained persons devoted to the discovery of scientific principles for its guidance and to practice in the application of its principles for the improvement of society. But there are many social

[1] See *Function and Training of the Psychiatric Social Worker.* MENTAL HYGIENE, Vol. 5, pp. 434-5, April 1921.

workers who have not yet answered this question even to their *own* satisfaction. The answer will depend on the practical consideration of whether the world needs a professional body trained for a service not already provided for, in theory at least, by the other professions—medicine, education, theology, and law. In a sanitary, educated, moral, law-abiding community, would there be any demand for professional social service? Or, if by accident, by failure to use opportunities, or by misuse of them, a certain number of the population fell into social disorder, could not these problems be met by doctor, teacher, clergyman, or lawyer, with the social consciousness that every practitioner of this enlightened future is expected to have and with some lay assistance to eke out his time? The state of society here suggested is at best very far off, but we do well to base our conception of social work upon principles calculated to survive the centuries. The future of social work depends upon whether the established professions, in theory at least, functioning to their utmost capacity, are sufficient for the prevention and cure of social disorder.

Let us consider what the social worker does. All the varied activities that come under the name of social work fall into three major divisions of endeavor: (a) to help the individual in social difficulty—*social case work;* (b) to promote social consciousness among groups—*community work;* (c) to improve community conditions—*through research, organization, legislation.* The common factor in all three divisions is the study of human relationships with a view to the better adjustment of individuals and groups to their environment.

We are here chiefly concerned with the first of these major groups, social case work, for it is within this field that psychiatric social work has developed. Its place in neighborhood and community work has not yet been found. How far the psychiatric social worker will enter into group leadership and community organization is a question for the future. To some extent she has already taken part in community mental-hygiene surveys, notably in the investigations conducted by the Canadian National Committee for Mental Hygiene. And at least one neighborhood-house director

has expressed the opinion that there should be a psychiatric social worker upon the staff of every neighborhood house.

Social case work is an effort to bring a person suffering from social difficulty into a sound social condition—that is, to borrow an expression I once heard, into a condition where "he can operate freely in an environment he has learned to control." The method of social work is (a) examination of the past life and present condition from data secured through investigation and observation; (b) analysis of these facts to determine the fundamental causes of the trouble; and (c) a plan of treatment by which all the elements of the individual's life are so organized as to effect the best adaptation to his environment that is possible for him. Social work, then, is equally concerned with all aspects of life and with all human relationships. Each of the four great professions of medicine, education, theology, and law, while also promoting the adaptation of man to society, has for its function attention to some *particular* aspect of human life and, although in dealing with an individual, it must necessarily take into consideration all sides of his life, all other aspects are subordinated to that one which is its particular concern. Social work is the only activity which deals equally with *all* conditions and *all* relationships of life.

The social worker must know enough about all the arts and sciences to be able to see that his patient or client has the benefit of them, and must render a further service, which is not simply connecting or amplifying *these other forms* of service, but is a *special kind* of service not afforded by any other practitioner. The special expertness that the social worker contributes is knowledge of how to effect adjustments between individuals and their environments and skill in bringing about such adjustments.

The patient or client who has come to the social worker for assistance may have difficulties in all of the five spheres of the "Kingdom of Evils,"[1] the classification that Dr. Southard devised to comprise all of the evils that exist—Disease, Ignorance, Bad habits, Legal entanglements, and

1 Southard, E. E., M.D. *The Kingdom of Evils: Advantages of an Orderly Approach in Social Case Analysis.* Proceedings of the National Committee of Social Work, 1918.

Poverty or Resourcelessness. The patient may be sick, ignorant, morally untrained, in difficulty with the law, or without resources, financial or otherwise. Whatever specialists may be needed in the case, the social worker deals with all of these conditions and reconstructs the total situation to the end that the patient may get on as well as possible.

The characteristic function, then, of social work is to know what constitutes sound social condition and how to secure it. Not a specialist in health, education, morality, law, or economics, but knowing something about each of these fields, the social worker is a specialist in the field of social adjustment. As society becomes more complex and the possibilities of maladjustment increase, at the same time our perception of what constitutes a sound social condition becomes finer. In the medical field, while the possibilities of disease increased, knowledge of causes of disease increased also, and higher standards of health were demanded. So in the sociological field may we not expect increasing possibilities of maladjustment, but at the same time better knowledge of causes of social disorder and the demand for higher standards of social life?

The professionally trained worker in any field is quick to see the earliest indications of trouble. The trained social worker now sees the potentiality of social disorder in signs that the unpracticed observer would not notice or would not elicit. In the future may we not expect that social case work will become preventive in the sense not only of correcting early signs of social trouble—which it is doing to some extent at present—but also of teaching principles of social adaptation and proper ways of meeting situations?

Experience in social work in hospitals has shown that it is not only groups below certain educational and economic levels that need the services of the social worker. Economic and educational factors do not determine the need for social assistance; therefore, it seems probable that in time social work will be a form of professional service available for all classes for both preventive and curative purposes.

This improved knowledge of what constitutes sound social condition and how to secure it must be gained through the study of individuals. However important the influence of the

group mind may be upon individuals, still the nature of the group depends, after all, upon the character of its units, and the action of groups is significant ultimately only in its effect upon individuals. All community effort has for its final purpose the welfare of individuals. In studying how life may be lived most successfully in a society, it is not enough to study only groups and communities, but we must go on to study the adaptation of individuals. From the social worker, who is the special practitioner in this field, should come eventually contributions to a new phase of sociology dealing primarily with individuals. Social case work may then be recognized as the art of applied sociology.

The fact that our theory and practice in social work are as yet poorly developed and crudely applied does not indicate that future progress will not follow lines of development similar to the history of other professions. In 1873 Herbert Spencer published a book which he began with the question: "Is there a social science?" Nearly fifty years later, we are face to face with the question: "Is there a social profession?" Sociology has now an established place among the sciences, although rumblings of Spencer's question are still heard in some quarters. We social workers of to-day are like the little creeks and rivulets that in the end go to fill a great reservoir. Perhaps another fifty years will see social work an established profession founded upon a science of sociology greatly developed in its individualistic phase.

If it be true that the task of social work is to promote social adaptation through the adjustment of human relationships, what is the place of psychiatric social work in this endeavor? The point of view of the psychiatric social worker is derived historically from the mental-hygiene movement, just as the point of view of the medical social worker is derived from modern developments in medicine, and the point of view of social work in general from the older philanthropic activities founded upon economic necessity. Upon this foundation of interest in the economic security of the family was laid the emphasis of medical social work upon health and upon the effects of disease in causing social maladjustment, leading to greater attention to the individual members of the family group and to a more profound view of

social troubles. The recent emphasis of psychiatric social work upon mental health and the relation of mental disorder to social disorder has begun to make its impression upon the point of view of social work in general. There is beginning to be a widespread recognition of the fact that complete study of a person involves attention to the economic, physical, and mental factors of his life and situation, and that it is not enough to treat him scientifically from the standpoint of economics or medicine and leave the consideration of his mental condition to intuitive or common-sense methods. A large proportion of applicants for social assistance have some mental condition that would be counted as disease and that should receive the attention of a psychiatrist (50 per cent is probably a very low estimate); but it is not only in the treatment of psychiatric cases that the social worker in general needs the point of view and knowledge of psychiatry. The study of human relationships and the art of adjusting right relationships have their foundation in mental attitude and personality, and future progress in social work will be based upon the understanding of mental processes. This knowledge must come from psychology and psychiatry—not from one of these fields only, but from both. Just as the social worker must know something of medicine as well as of biology, so some knowledge of psychiatry is necessary in addition to psychology for understanding individual personalities.

When every social worker shall have acquired this knowledge as part of her regular training, will there still be need of a specially trained body of psychiatric social workers? The practical consideration that certain social workers will elect to work in the field of mental hygiene in assistance to psychiatrists would seem to answer this question. Through the study of pathological cases, principles are discovered that may be applied in all cases. It should be the function of the special psychiatric social worker dealing with psychopathic patients to find principles and methods for the improvement of human relationships that might be applied in the whole of social work. We see to-day the beginnings of this tendency. The director of a family agency, which employed a psychiatric social worker upon its staff to deal with psychopathic cases, said that the greatest benefit derived from the psy-

chiatric social worker, even more valuable than her own direct work, was an improvement of all the case work in the agency through her influence.

It is especially desirable that the psychiatric approach to case work should be stressed in those fields of social work that are preventive rather than curative. The two great opportunities for preventive social work are in the school and in industry. In each of these fields social practice has to be adapted to the special conditions of educational and industrial organization, but the principles and essential technique of social case work are employed. The cumbersome name "social worker" may become submerged in a name that designates the special function performed.

There is a movement now well under way in the schools to provide a social service through visiting teachers. The visiting teacher is essentially a social case worker familiar with educational methods, in some instances through having been herself a teacher. It would seem to be of the greatest importance that the earliest practitioners in this field should be well grounded in the principles of mental hygiene in childhood. The right of the child in school to protection in matters of general hygiene has been recognized and practical measures for the health of school children are being introduced as fast as possible. But so far there is very little recognition of the child's right to mental hygiene. One of the most effective ways of carrying mental-hygiene principles into the school would be through the visiting teacher, who deals with the child in all parts of his environment—school, home, and community.

In industry, the function of the personnel worker is essentially the function of the social worker. His aim is to keep the employee adjusted to his work. To do this successfully, he must take into consideration personal and family conditions; for the way a man gets on in his work depends upon the adjustment of his personality, not only to the conditions of his employment, but also to his home conditions. Any form of social disorder will interfere with a man's working capacity. The personnel worker should seek to help the employees to preserve that total social adjustment which will promote both their happiness and their efficiency. He is con-

tinually called upon to make social diagnoses, usually upon an incomplete social examination. It is not usually possible at the present time for him to make a thorough social examination of every employee who shows symptoms of social difficulty, both because the staff of the personnel department is not sufficient for the required outlay of time, and also because public opinion still looks askance upon the social examination. There was a time when a thorough medical examination was often regarded as a personal affront. In time the prejudice against a thorough examination of a person's social condition by a professional adviser will doubtless be outgrown. Meanwhile the personnel worker who is called upon to make snap diagnoses is all the more in need of the skill and keenness that come from practice in intensive social work.

It seems particularly important that the industrial social worker should have experience in psychiatric social work—special training, that is, in the study of personality. The connection between personality and employment is one of the most vital human relationships, and it is impossible to think of successfully fitting a man to his work without understanding the nature and habits of his mind. The personnel worker, who has this function to perform, should have the benefit of all the knowledge that psychiatry can contribute to social work.

In the prevention of social disorder the personnel worker equipped with the point of view of mental hygiene has a large opportunity both to preserve happiness and promote efficiency. Temperamental difficulties, peculiarities, unfulfilled longings, disappointed ambitions leading to conduct that makes trouble in the shop and creates involved situations at home, when properly understood and dealt with from the psychiatric standpoint, may often be rendered quite harmless. The promotion of mental hygiene of industry would do a good deal toward the prevention of social disorder.

The general public is at the present time highly receptive to ideas of mental hygiene, to such an extent that any practitioner or panacea advertised with assurance as a mental help readily gets a following. At the same time there are comparatively few persons who regard mental disease with the

same objectivity with which they regard physical disease. And most persons still think of mental hygiene only as a means of avoiding mental disease. The social worker is probably the best agency there is for spreading better information concerning mental health and mental disease. In every case she deals with she interviews numbers of persons, anywhere from five to twenty-five, possibly. Both by her attitude toward the patient in question and by what she tells about him, she leaves behind in every interview an impression that the trouble is a disease to be regarded as other diseases. Moreover she has countless opportunities to talk with family, relatives, friends of patients about mental hygiene as a means of increasing happiness and efficiency. This responsibility for public education should be consciously part of the duty of the psychiatric social worker in particular.

In considering the educational value of psychiatric social work to the community, I have spoken only briefly of its influence upon psychiatry and upon public education and have discussed almost entirely the influence it is exerting upon social work, because the benefit to the community of this latter influence will, I believe, outweigh in extent and importance all other effects that psychiatric social work may have.

MENTAL HEALTH CLINICS*

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THE realization of the importance of mental health to the welfare of the individual and the community has grown at a rapid pace as a result of the experiences of the past few years, and yet even to-day the far-reaching importance of this factor is but vaguely appreciated and for many people the term arouses little more than thoughts of insanity and feeblemindedness. These two varieties of mental ill health, though striking and more or less obvious, are but a fraction of the real problem. The size of it is better indicated by stating that the ability to adjust to the conditions of social life, to subordinate the individual to the good of the group, and to find an outlet with satisfaction for those longings and cravings which are innate and inherent in life itself without harm to social relationships is dependent upon mental development.

Even in such an organization as this conference, the continued existence of a section devoted to mental hygiene has been somewhat precarious, possibly because psychiatric problems are so universal in social work that every section is vitally concerned in them. While it is probably true that a small proportion of social work is rendered necessary as the direct outcome of illness, accident, or defect, yet it is becoming increasingly evident that the great bulk must be referred to mental ill health. The problems presented by the former group are relatively simple, but where difficulty in satisfactory settlement is met, there will always be found some mental problem. While it may not be quite true to say that every case in need of social service is a psychiatric one, the reverse—that every psychiatric case is a problem in social adjustment—is unquestionably true. Social existence, with the necessary control of individual desires that it implies,

* Read before the Mental Hygiene Section, National Conference of Social Work, Milwaukee, June 28, 1921.

is impossible without a corresponding mental development, in which is included not merely intelligence, but also the manner in which this is used. In other words, psychiatry is the science of behavior.

Obviously, behavior must depend partly upon the tools with which the individual must operate—the health and efficiency of the various organ systems of which the body is composed and especially of the nervous system, which serves to select and coördinate the activities of the others into that integrated whole which we call behavior—but this is not all. Good—that is to say, socially acceptable—behavior may exist in spite of even severe organic handicaps and, conversely, unsocial behavior—insanity, crime, etc.—may appear in spite of well-formed and healthy organs. Behavior also depends in part upon training and experience in the use of the organs available. Such a conclusion seems to me unescapable in spite of the time-honored dictum of *mens sana in corpore sano,* which, in my opinion, has done much to retard the development of psychiatry.

All persons are not born with an equal equipment in the way of working tools or of vital energy. Hence it is readily intelligible that, even with identical opportunity in the way of training and experience, some individuals will surpass others in the successful adjustment of their innate personal desires to the restrictions of society. Some are so poorly equipped with nerve connections or so differently constituted in that elusive, but intensely important, quality alluded to above as vital energy, however it be determined, that shipwreck is certain under the ordinary routine of life and training, even though these are satisfactory for the average person.

It is of practical importance in connection with the establishment of the mental-health clinic, to note the interest that has developed in tests of intelligence, not only as scientifically standardized by psychologists, but also as used by employers of labor and others. Unfortunately these tests have been pushed into a prominence and given a significance that does not belong to them, with the consequence that their very real value is liable to be forgotten in the failures that follow from too large claims for their applicability. As a matter of fact,

whether overtly or covertly, these tests, when used alone, are usually supplemented by personal estimates of behavior characteristics not founded upon the tests, but included as a part of the report of the findings. Such tests are measures of endowment of a certain kind, and as such are of the greatest value in assisting to determine explanations for behavior and the limits of plans for its improvement and development.

While it may be unnecessary before this audience, it is important for our purpose to insist upon the need for a conception of mentality that does not regard the "mind" as a separate and distinct organ or entity. Mind is not a thing, and hence is not subject to disease as this term is usually understood. Mental activity represents only the activity of "the body as a whole" under the guidance of individual experience and training. These last are effective chiefly through nerve connections in the brain which, when in action, are consciousness. Mind is therefore not a separable, independent entity, a realm in which guardian angels and evil spirits struggle for victory, nor is it governed only by inheritance and thus the special field for eugenics and euthanasia. In studying mentality, it is necessary to take into account not only the endowment with nerve connections of the brain (intelligence) and lower parts of the nervous system, together with all the various body organs, but also the training the man has received by his individual experience in the use of these endowments. Furthermore it is obvious that treatment of mentality must be fundamentally educational in the broadest sense of that term, due consideration being given to deficiencies and handicaps in endowment or arising from disease or accident.

Mental health must, therefore, be the most important factor both for the welfare of the social group and the happiness of the individual. Its province extends far beyond the realms of insanity, which represents only certain forms of mental ill health that require segregation from society because of the dangers that result from his behavior to the patient or his surroundings. It enters into the immense fields of dependency, delinquency, and crime, and furthermore it is concerned with untold numbers of chronic invalids, usually

grouped as nervous or neurotic, who form such a large proportion of the clientele of the general physician and the specialist, as well as of irregular practitioners, fakers, and the various cults. Clinics (the word implies the presence of beds, but this true meaning is now practically eliminated by usage) for the study and treatment of diseases of various parts of the body have long been in existence, and it seems but logical that others devoted to the study and treatment of the man as a whole, his behavior, are at least equally important and equally medical. Yet the number in existence is extremely small and those largely of recent development. The problems are as yet but poorly defined, and it is probable that experience will bring many modifications and developments in the near future.

Before discussing the needs in general terms, it seems wise to illustrate by actual experience. For this purpose I will quote some figures derived from 100 consecutive cases seen at a clinic maintained in Chicago at the dispensary of the College of Medicine of the University of Illinois, with the coöperation and assistance of the Illinois State Department of Public Welfare. Under this plan, which is as yet only partly in operation, there are maintained two separate clinics; one, for the study of children, known as the Institute for Juvenile Research, is under the direction of Dr. H. M. Adler, who is also criminologist of the department, while the other, for adults, is under my own direction. It is from the latter that these figures are taken. This clinic has been developed in the department of the general dispensary devoted to nervous diseases, and for that reason possibly receives more strictly neurological cases than might be true in a clinic developed primarily for mental health. The combination, however, seems to be an excellent one, for the reasons that it helps to diminish any objection there might be upon the part of patients to a clinic bearing the title psychiatric or psychopathic and that a large proportion of the patients of any neurologic clinic are strictly mental cases. At the present time, the clinic is handicapped by the absence of beds and wards for the special observation and study of suitable cases, though a hospital for this purpose is now in course of erection. There is also an absence of some desirable facilities

for treatment, the lack of which is felt continuously. These also will be provided in the new quarters.

In Table I have been grouped the reasons that led the patient to come to the clinic. It must be understood that many of the cases might well be included in several different groups, but it was thought best to indicate only the problem that seemed to stand out most prominently in each case.

TABLE I

Problems Presented

Inability to manage home	7
Friction in the home	10
Sex and other delinquencies	8
Dependency	6
Failure in work	7
Mental excitement	5
Despondency	3
Fits	6
Bodily complaints	43
Special reasons	5

Under the heading of bodily complaints have been placed not only the more strictly neurologic difficulties—such as paralyses, blindness, etc.—but also many psychoneurotic complaints—such as nervousness, insomnia, headache, etc.—which have led the patient to seek assistance on his own initiative or on the advice of friends or physicians. Such cases often have not as yet become definitely social problems to the general public, but they are inefficient, more or less dependent, and, where money is scarce, are liable to become burdens upon society, very probably dragging others with them. Under the heading special reasons have been grouped cases referred for Wassermann or other tests or for examination as to fitness for mothers' pensions, etc.

It will be noted that 38 per cent were referred because of definite difficulties in social adjustment and an additional 8 per cent because of mental symptoms that caused upsets in the social environment. Thus approximately one-half the cases have already been recognized as social problems.

The diagnoses reached are shown in Table II.

TABLE II

Types of case

Mental deficiency	26
Defective delinquency	4
Inadequate personality	1
Epilepsy	5
Psychoses with organic brain disease	4
Psychoneuroses	26
Dementia praecox	6
Manic-depressive reactions	4
Neurological cases	18
General medical cases	2
Negative findings	4

It will be seen from this table that mental deficiency, combined with the related groups of defective delinquent and inadequate personality, constitute about one-third of the cases. The psychoneuroses come second, and it is of interest to note further that many of the cases placed in the group of mental defectives also presented psychoneurotic symptoms. This is undoubtedly due to the fact that the struggle for existence and self-expression under social regulation is rendered much more difficult by reason of the lack of intelligence.

In Table III is given a list of the agencies concerned in bringing this 100 patients to the clinic. It is not a complete list of those which have referred cases, but it is a sufficient indication of the widespread relations concerned.

TABLE III

Agencies by which referred

Other departments of dispensary	22
Institute for Juvenile Research	4
Juvenile court	3
State attorney's office	1
Jewish Social Service Bureau	26
Illinois Society for Mental Hygiene	3
Visiting Nurses' Association	3
Juvenile Protective Association	2
United Charities	5
Immigration Industrial Commission	1
American Red Cross	1
St. Vincent's Orphanage	1
Northwestern University Settlement	1
Social-service department of industrial corporation	1
Voluntary application or physician	26

The character of the treatment recommended is shown in Table IV. The social supervision, in the great majority of instances, has been furnished by the particular agency that referred the patient to the clinic; in a small minority by workers attached to the clinic.

TABLE IV

Treatment recommended

Institutional	13
Social-service supervision	39
Transfer to other dispensary departments	7
Treatment in the clinic	41

It is probable that commitment to an institution for the feebleminded would be recommended in more cases were it not for the fact that there is no space available for such cases in the state. Almost all the cases of mental deficiency belonged in the higher grades of the moron or border-line groups, and many of them were married, with families of varying and often constantly increasing size. It is this last factor that renders them especially difficult, not only because it tends to the development of a steady increase in the numbers of the feebleminded, but also because the increasing burdens soon outgrow the parents' earning capacity and ability to plan, and there is liable to ensue desertion, dependency, illegitimacy, etc. If the growth of these families could in some way be curtailed, many of them could remain more or less completely self-sustaining, useful, and at the same time satisfied, and thus without menace to the community. These remarks, of course, do not apply to those cases where there is at the same time a habit of delinquent behavior. Under existing conditions, it has been necessary to make the best disposition of such cases that seemed possible by providing supervision of household expenditures and plans, assisting in employment, supplementing earnings, etc.

In addition to work with new cases, there is also a large field for the mental-health clinic in the after-care and supervision of patients when paroled or discharged from state hospitals. None of these have been included in the above 100 cases. The homes of such patients are often far removed from the hospital, and in addition there is often considerable reluctance towards returning, even for a visit.

These preliminary considerations seem to justify the following general statement of the requirements for such a clinic.' Its purposes may be defined as:

(1) Diagnosis;
(2) Treatment without interruption of social relations;
(3) Early hospitalization where advisable;
(4) Continued treatment after de-hospitalization;
(5) Research into the causes and treatment of mental disorder.

By diagnosis is meant not merely the placing of a name upon the particular type of mental disorder, but also the determination of the factors that have already led, or are liable to lead, to difficulties in adjustment. From what has already been said, it is obvious that this implies a study of the bodily and mental equipment and of the behavior of the patient, and, in addition, of the social or environmental influences that may be responsible for his methods of reaction. The results of all these investigations must then be synthesized and correlated.

In addition to the psychiatrist in charge of the clinic, it is advisable to provide for technical assistants to conduct intelligence and laboratory tests, and since many problems in the various medical and surgical specialties must inevitably arise, it is especially desirable to have ready access to consultation with these other departments of dispensary service. A few beds, which will permit detailed observation of behavior under controlled conditions and permit also the performance of some of the laboratory tests, are also essential for thorough work.

But since the problems with which the clinic is concerned are essentially social, it is obvious that trained social workers to investigate conditions in the home are absolutely necessary. Such assistance, under favorable circumstances, may often be secured by coöperation with the agencies that refer patients to the clinic, but it is to be remembered that frequently success in treatment and the avoidance of more serious difficulties will depend more upon the quality of the social worker than upon any other factor.

The treatment may be considered under two headings: first, that which attempts to correct the deficiencies or faults

in the patient; and, second, that which is designed to modify the conditions under which he must live. The former concerns (a) the remedying or minimizing of handicaps due to disease or defect, in which assistance is often necessary from other medical or surgical departments of a general dispensary service; and (b) the application of psychotherapy, which means the education of the patient in the nature of his difficulties and their mode of origin, with advice and assistance in adopting more satisfactory methods of meeting them. Valuable assistance in this procedure can be secured from hydrotherapy, electrotherapy, occupational therapy (used, not as a means for vocational training, but as an education in habits of application and the development of outlets for self-expression in the form of hobbies, artistic interests, etc.) and employment and recreational agencies.

In the modification of the environment, trained social workers are again essential if the patient is to be kept in the community and does not need to be removed temporarily or permanently to the simplified conditions of a hospital or colony.

In some cases it may be permissible for the clinic to secure a certain measure of legal authority over a patient which will be respected by him. This can be brought about by means of probation from juvenile, domestic-relations, or other courts or by preliminary commitment to and parole from a state hospital. Such steps, however, must be taken only with the most careful consideration, as it is absolutely essential that the patient realize that the clinic is working for and not against him. For this reason it is preferable that such steps be taken by some other agency.

The location of the clinic need not detain us; it should be as easy of access to its patients as possible and, as already pointed out, in close proximity to, preferably a part of, a general medical and surgical dispensary. The hours of operation are, however, important in view of the fact that the difficulties to be remedied are those of social adjustment. For this reason it is especially desirable to disorganize the hours of employment of the patient as little as possible. Hence evening hours should be arranged for those who cannot come during work hours.

For securing contact with patients, affiliations must be established with all organized public-welfare agencies—schools, churches, courts, police, charitable organizations, etc.—with the medical profession, and, by popular lectures and demonstrations, with the people of the community.

The source of supply of the psychiatrists to take charge of these clinics will probably vary with conditions. In large cities it may be possible to secure the services of trained neuropsychiatrists in private practice, but in many instances, especially in the smaller communities, this service should be provided by the state hospitals. The clinics serve, not only for the after-care of patients on release from the hospital, but also as a source of information concerning the history of patients before commitment and as an agency in securing early commitment where required and in preventing unnecessary commitments. In addition, the contact serves very materially to broaden the psychiatric knowledge and experience of the physician and does more than anything else to establish acquaintance and confidence between the community and the hospital.

Difficulties sometimes arise from a fear on the part of the local physicians and social agencies that the attempt to establish a clinic, with the state-hospital physician in charge, represents an effort to develop a system of state medicine. This must be met by education, and it is preferable for the initiative to come from the community. We have found that when arrangements are made for a clinic for the care of patients on parole from the hospital, it is not long before requests are received for the examination of cases referred by physicians and others. The clinic then acts purely as a consultant, leaving the actual application of the treatment to the local physician or other agency.

THE SIGNIFICANCE OF SPIRITUALISM

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SPIRITISM — or, as it is more commonly known, spiritualism—may be defined as "the belief that disembodied spirits exist and manifest themselves to men." (Baldwin) It is our purpose to attempt an inquiry into the cause or causes underlying this belief and to discuss its significance. An interesting and concise study of the subject has been recently published by Randall,[1] and in the present paper frequent reference will be made to this contribution.

Belief in life after death has existed among practically all peoples at all times, and such universality of belief has been argued as a proof of immortality—"the proof from universal consent."

A second argument for immortality may be called a psychological one, "based upon man's instinctive aspiration toward the ideal—the ideal of beauty, truth, or goodness. But since this ideal never is and never can be attained in this earthly life, therefore, there must be another life where it can be realized; otherwise man's deepest aspirations are baseless delusions and cruelest mockery."

A third or metaphysical argument for survival after death is that while the "body is composite and corruptible, the soul is simple . . . a part or fragment of Infinite Being or Universal Substance; therefore, after the terrestrial life is terminated, the soul must continue to live on, as nothing that is a part of indestructible substance can ever be lost or destroyed."

Fourth, there is a moral argument which claims that it is just that the righteous receive their reward and the guilty punishment, and that since a state of complete justice does not obtain in this life, right would not prevail unless there were some opportunity for justice to be attained hereafter.

[1] *The New Light on Immortality or the Significance of Psychic Research.* By John Herman Randall. New York: The Macmillan Company, 1921.

Finally there are the arguments for survival after death from religion—the promises of everlasting life with God, as set forth, for example, in the Bible.

Obviously, no one or all of these arguments furnishes conclusive or final proof of life after death, although those who accept or believe them, particularly the arguments of religion, are prone to take it for granted that survival after death has been proven. There is no doubt that such arguments, leading to conviction, have given comfort and hope to countless persons.

Such convictions of immortality were undoubtedly more prevalent before the present age of science. During the last century, particularly, the spirit of scientific investigation has entered the field of religion, and the result of scientific investigation of the origin of Christianity and of the sources and development of Christian theology has been that many of the traditional beliefs have been swept away. If the leaders of religious thought had seen the light, recognizing that the old theologies were poetic mythologies containing truths that could be applied to-day to men's lives, and had not insisted rigidly on dogmas and creeds, contentment and peace of mind might have been maintained as before with the application of religion to the present age. But with the props of belief torn away and no supports from the church, there was left doubt, uncertainty, or frank disbelief in the old religion. Science was investigating facts elsewhere and undertook what was supposed to be a scientific investigation of immortality. We submit, however, that although the expressed purpose of the societies for psychical research, formed in the eighties and still in existence to-day, was and is the scientific collection of facts on the subject of psychic phenomena and manifestations of spirits, the determinant of these investigations was and is a conscious or unconscious need for survival after death, which need is the result of a dissatisfaction with or lack of completeness in the present life. This is the why of spiritualism to us. In our opinion, therefore, the acceptance of the idea of survival after death—and the belief, as indicative of this, in the psychic manifestations observed—rests rather with the emotions than with reason, and spiritualism, like religion, is a matter of faith and not of scientific fact or proof.

We may exclude from our argument those persons who by means of conscious fraud or even unconscious self-deception obtain a livelihood through the practice of spiritualism. Their need is a material one. And we think our argument as to the emotional basis of spiritualism will be readily accepted as applying to those individuals who, becoming absorbed and dominated by spiritualism, show reactions closely similar to those that we find in the psychoses and in hysteria, with the acceptance of hallucinations and apparitions as true. The desire, conscious or unconscious, to get away from difficult or intolerable reality is operative in the spiritualist as well as in the psychotic.

Likewise we may perhaps assert that there can be little question that the wish to believe that the departed survive and communicate with the living determines the acceptance of that belief by those recently bereaved through the loss of loved ones. There is a longing in such persons to remain in communication with those who were recently here, and the apparent demonstration of such communications gives solace and comfort and makes life more bearable. Those of us who have lost members of our families may have found comfort in believing that eventually we should again meet and commune with those of whom it may have been said, they "had gone to a better world." And in the heightened emotional state immediately following such losses, it might have taken much less to convince us of actual communion or communication than it would in a later period, when we had resumed our more normal or usual emotional levels and had our interests diverted by the actualities of life around us.

More doubts might arise, however, as to the validity of our arguments that belief in survival and in spiritist phenomena depends on a desire to believe, with the accompanying emotional background, when we consider the men of science who have spent much time in what they assert and believe to be exact scientific investigation, controlled by reason and not influenced by emotion. We believe, however, that even for them, our argument still holds true. One point in our favor is the fact that, with evidence identical with that on which some scientists have accepted belief in spiritualism, more or perhaps the majority of scientists, if not convinced of the falsity of the

belief, are at least not convinced of its truth. We believe that the attitude of this latter unconvinced group may well be the result of more satisfaction with reality and of less need of a hereafter than is present in the "believers." Another point of interest is the difficulty of convincing the believer of fraud in the medium, as was shown, for example, in the case of Paladino. This refusal to see fraud is to our mind the result of a wish not to see it or of a wish to believe.

But let us inquire into the attitudes and motives of some of the individuals who have made so-called scientific investigations of spiritualism, to determine whether our argument holds true. At once the names of Hyslop and Lodge come to mind as outstanding figures in the field of spiritualism.

Those who knew Hyslop were in a better position than we are to determine the motives that actuated his interest and influenced his conclusions as to the truth of spiritualism. I refer to Randall for the following significant statement: "It was long ago, probably even before he came to devote himself entirely to investigation in the psychical domain, that his writings revealed plainly enough, and not involuntarily, how strong was his own inclination to believe, not only that the dead are somewhere alive, but that they can and do send messages in various forms to the living. It was this predisposition to believe that doubtless led him eventually to devote his talents exclusively to these subjects. However, it was not until late in his life that he came out frankly and publicly on the side of the spiritistic hypothesis. Before that, he carefully and somewhat laboriously maintained the attitude of a disinterested seeker after truth, of the possessor of the open mind, ready to follow wherever the facts might lead him. It was quite evident that he was fighting against his own natural desire to believe, in his desire to base his final conclusion on what he deemed to be purely scientific evidence." Whether one can maintain an open scientific attitude of mind in investigating what one wishes to believe is a question. That Hyslop's desire to believe was determined by a feeling of need of survival we may indicate by some quotations. In speaking of skepticism, he said: "It might insist on natural laws, but it was always menaced by the prospect of contending with human needs which have as much influence in deter-

mining many beliefs as any of the rigid standards of evidence." Again, "There is no truth that can be made more helpful to man than a belief in survival." Further, ". . . the prolongation of consciousness which is the aspiration of every effort man makes in his life." ". . . if we find that nature assigns this [sensuous life] a secondary place and means to preserve the inner spiritual life for further cultivation, the sacrifice of the physical and sensuous is rendered more easy. . . ." ". . . . if we find that survival is a part of her [Nature's] scheme, the bitterness that would haunt us if we were without hope will be less poignant." "The sadness of sunset is only sublime pathos when we are assured of another dawn." These fragments indicate to us that Hyslop's spiritual interests and convictions were influenced by his innermost wishes and a feeling of need of survival because of a lack of fullness and satisfaction in this life.

If it were a fact that Lodge's conviction of the truth of spiritualism had followed upon the death of his son during the war, with the son's subsequent communication, we might pass this over with the assumption that the conviction arose from a highly emotional state of bereavement such as we have previously mentioned. But he was convinced of survival and of spiritualistic manifestations before that event close to his heart took place. He had come to this conviction following psychic research, but it is interesting to note that, before he undertook such research, he was of a religious turn of mind. He was not a materialist. As Randall points out, he regarded the universe as being essentially spiritual, though manifesting itself through the material. He believed there was something more to man than his physical body; light, mind, and consciousness to him did not belong to the material world and were something quite distinct from matter and energy. It may be perhaps safely assumed, therefore, that there was the wish to believe before spiritualistic investigation was undertaken and that, like Hyslop, Lodge saw what he wanted to see, with an accentuation of the fulfillment of this wish after his son's death.

In contrast to the initial and final attitudes towards spiritualism assumed by Hyslop and Lodge are those of William

James. He felt that "immortality is one of the great spiritual needs of man" and that it has its prime roots in personal feeling, but he said: "I have to confess that my own personal feeling about immortality has never been of the keenest order and that among the problems that give my mind solicitude this one does not take the very foremost place." James is described as a nonconformist in science as well as religion. He admitted that there was something in him that was forever impelling him to search for the one "white crow" which would disprove the commonly accepted proposition that "all crows are black." "The unpopular view" had a peculiar fascination for him. It has been believed that it was his nonconformist attitude that stimulated James' interest and activity in psychic research when it was looked at askance by his friends and colleagues. In the research he evidently recognized the possibility of emotional influence on the interpretation of psychic phenomena, stating that he had expected that his verdict would be determined by "pure logic," but found that logic had played only a "preparatory part" and that the "decisive vote, if there be one, had to be cast by what I may call one's sense of dramatic probabilities." After twenty-five years' experience, James wrote, the year before his death, "I am theoretically no 'further' than I was at the beginning," and also, "I personally am as yet neither a convinced believer in parasitic demons nor a spiritualist, not an 'orthodox scientist,' but still I remain a psychic researcher waiting for more facts before concluding." Approaching the subject from a scientific, unbiased point of view, he seems to have maintained a scientific attitude and to have arrived at scientific conclusions regarding spirits. We may assume, perhaps, that there was little need in him for personal survival or for communication with the dead.

With the feeling that the truth of spiritualistic belief has not been proven and that the belief springs from a need that is not satisfied in this world, the question arises, "What had best be our attitude toward it?" Our answer is that this depends upon the individual. Just as we would not believe in trying to take away from an individual a religious belief that was a comfort to him and made life more tolerable and at the same time made him of more benefit and comfort to

others, so we would not believe in trying to take away spiritualistic belief that had the same effects. Any person has a right to believe what makes him a better member of society. On the other hand, how often do we see the bad effects of spiritualistic belief—absorbing the individual, cutting him off from interest in or contact with others, making him unproductive and not only of no help to others, but a burden to them. Here the situation is different, and certainly it is incumbent upon us to attempt to direct such unhealthy activities into more productive channels. The possibility of redirection in such persons obviously depends upon the strength of the wish to believe, the depth of fixation of the belief, the ability to obtain new outlets, and possibly the personality of the redirector.

I imagine that many of us are not deeply concerned from day to day with the question of our own survival after death or with the question of whether or not the dead can or do communicate with us, and I take it that this is because we are more concerned with the life of reality about us, in our contact with other persons, with our aim to help to make life happier and more complete for those with whom we come in contact, and that in so doing we are deriving a satisfaction and happiness ourselves that leaves little if any feeling of need for a more attractive world beyond. There is so much around us to be done that we seldom raise our eyes from this earth and gaze longingly toward that infinite heaven which to the spiritualists and to many others is the only place where there is an opportunity to live out one's destiny in completeness. Although all is not joy and happiness here, I take it that we are trying and striving to make this earth a better place to live in and thereby fill our lives still more completely. If only the individuals with eyes and ears so intent upon another world could bring their eyes back to earth and live in reality, they would very likely find that the world here and now, in which they seem to find only misery and unhappiness, is not such a bad place after all.

LAWS CONTROLLING COMMITMENTS TO STATE HOSPITALS FOR MENTAL DISEASES*

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LEGISLATION relating to the hospital care of mental diseases has for many years been based almost entirely on the assumption that the only question at issue was the protection of the community from the so-called insane. Very little consideration has been given by the framers of our laws to the welfare of the patient. The word insanity itself is a purely legal and not in any sense a medical conception. It may be said to relate to mental diseases only in so far as they come within the jurisdiction of a court. Nor have those who have been responsible for the use of this term in our legislative enactments any clear conception as to its meaning. It has usually been used synonymously with lunacy, a word that was written into the laws of England in 1320 in the reign of Edward the Second and appears there to-day. Von Feuchtersleben, who wrote a surprisingly progressive treatise on mental diseases in 1845, was unwilling to go on record positively as saying that the moon has no influence on the human mind.

A reference to the Massachusetts and New York statutes of the present time will show what progress has been made in our legal nomenclature since that time. Mental diseases are referred to in the Consolidated Laws of New York in terms of lunacy, and defined as including every kind of unsoundness of mind except idiocy. (Section 28, Chapter 27, Consolidated Laws of New York.) The Revised Laws of Massachusetts specify to-day that "the words 'insane person' and 'lunatic' shall include every idiot, non compos, lunatic and insane and distracted person." (Section 5, Chapter 8, Definition 6, Revised Laws of Massachusetts.)

* Read at a meeting of the Mental Hygiene Section of the Rhode Island Conference on Public Welfare, Providence, December 9, 1920.

The use of such words as lunatic, lunacy, asylum, alienist, et cetera, is limited now very largely to the court room and the newspapers. More modern legislation relating to the forms of mental disease that render the individual subject to legal custody is illustrated by the Civil Code of Illinois. This defines an insane person as one "who by reason of unsoundness of mind is incapable of managing his own estate, or is dangerous to himself or others, if permitted to go at large, or is in such condition of mind or body as to be a fit subject for care or treatment in a hospital or asylum for the insane." A person is legally insane in Alabama "who has been found by a proper court deficient or defective mentally, so that for his own or others' welfare his removal is required for restraint, care, and treatment." The interest of the law in mental disease may, therefore, be described as one of either personal or property responsibility. The more important question of criminal responsibility is one that is too comprehensive for proper consideration at this time.

The necessity of some form of legal commitment to hospitals for mental diseases is based on the fundamental principle in English law that no man can be deprived of his liberty without due process of law. This right was clearly recognized in the Magna Charta granted the English people by King John in 1215 and is specifically mentioned in at least two different articles in the Constitution of the United States—Article V and Article XIV. The established form of procedure which is now generally followed in all parts of this country includes (1) an application for commitment to an institution, (2) the medical certificate of two or more duly qualified physicians, showing that the person whose commitment is petitioned for is insane within the meaning of the law and is a proper subject for care and treatment in an institution, and (3) the order of a court of record for commitment to a state or private hospital.

In some states the petition may be made only by certain persons specified in the law, usually the parents, relatives, guardian, or friend, or certain public officials. In some states any person may make the application. In Florida the application must be signed by five reputable citizens. This does not seem to be a material point in law. Some courts insist

that a notice of such an application must be personally served upon the person whose commitment is asked for in the petition. In New York such a notice must be served at least one day prior to the hearing of the case unless the judge shall show in a certificate some adequate reason why personal service has been dispensed with, or that substituted service was made upon some other person designated by him. This is a wise precaution in view of the fact that the constitutionality of commitments without personal service has been questioned. The medical examiners are usually required to be graduates of a reputable medical school and licensed practitioners in medicine, with not less than three years' practical experience. On the filing of an application for commitment, a warrant of arrest is issued in some states and various forms of temporary detention provided for. This would not appear to be necessary in most instances. It should at least be discretionary with the court. The court may or may not allow the alleged insane person a hearing. This is usually, and should be, discretionary with the judge, unless a formal demand for a hearing is made. When this is done, notice of such a proceeding is usually served upon all persons immediately concerned. Formal hearings are required in all cases, the alleged insane person being present, in a number of states. Usually the question as to the presence of the patient is left to the court. Obviously it is often impossible. Trial by jury is often discretionary with the court, or may be granted on demand, and is required in all cases in Georgia, Kentucky, and Wyoming. There would appear to be no reason why a jury trial should be necessary or even advisable in any other than criminal cases. A determination of the mental condition of the alleged insane person is often made by a referee or a commission appointed by the court at its discretion. Nebraska, New Jersey, Iowa, North Dakota, and South Dakota have commissions in lunacy in each county. Practically every state has made provision for appeal from the decision of the court in matters of commitment.

When an insane person has been committed to an institution, it is usually the duty of the sheriff or some other court officer to remove the patient to the hospital. The order of the court in Massachusetts includes the following: "NOW,

THEREFORE, You, the said Sheriff, Deputies, Constables or Police Officers, and each of you, with necessary assistance, ..., are hereby commanded, in the name of the Commonwealth of Massachusetts, forthwith to convey the said ..... to the hospital ..... aforesaid, and to deliver h.... to the Superintendent thereof, and make due return of a copy of this precept with your doings therein." This makes the removal of the patient to the hospital to all intents and purposes practically the same as in a criminal proceeding.

Attention should be called to one of the very excellent and humane provisions of the New York law: "All county superintendents of the poor, overseers of the poor, health officers and other city, town, or county authorities, having duties to perform relating to the poor, are charged with the duty of seeing that all poor and indigent insane persons within their respective municipalities are timely granted the necessary relief conferred by this chapter. The poor officers or authorities above specified, except in the city of New York and in the county of Albany, shall notify the health officer of the town, city, or village of any poor or indigent insane or apparently insane person within such municipality whom they know to be in need of the relief conferred by this chapter. When so notified, or when otherwise informed of such fact, the health officer of the city, town, or village, except in the city of New York and the county of Albany, where such insane or apparently insane person may be, shall see that proceedings are taken for the determination of his mental condition and for his commitment to a state hospital. Such health officer may direct the proper poor officer to make an application for such commitment, and, if a qualified medical examiner, may join in making the required certificate of lunacy. When so directed by such health officer, it shall be the duty of the said poor officer to make such application for commitment. When notified or informed of any poor or indigent insane or apparently insane person in need of the relief conferred by this chapter, such health officer shall provide for the proper care, treatment, and nursing of such person, as provided by law and the rules of the commission, pending the determination of his mental condition and his com-

mitment and until the delivery of such insane person to the attendant sent to bring him to the state hospital as provided in this chapter."

In New York City these responsibilities are delegated to the trustees of Bellevue and allied hospitals and in the county of Albany to the Commission of Public Charities. In New York City a nurse or medical examiner—or both—from the psychopathic wards of Bellevue Hospital is sent "to the place where the alleged insane person resides or is to be found." If in the judgment of this examiner medical care is necessary, the patient is taken to the psychopathic ward for observation for a period not to exceed ten days. When a patient has been committed to a state hospital in New York, the superintendent is required by law to send a trained nurse or attendant to bring the patient to the institution. The advisability of having such cases under the immediate care of trained nurses who have had an adequate psychiatric training should receive the serious consideration of all authorities charged with the commitment of persons to hospitals for mental diseases. There is no reason why persons suffering from mental diseases should be subjected to the same form of supervision that is given to criminals. The New York plan of holding the health officer responsible for providing proper hospital care and treatment for mental cases that do not come directly under the legal jurisdiction of other persons or officials is worthy of consideration and should be adapted to the needs of other communities. There would appear to be no reason why the health officer should not logically be responsible for mental conditions in somewhat the same way that he is for communicable diseases. To what public official can the supervision of the insane pending commitment more properly be entrusted?

In twenty-nine states provision has been made for the reception of voluntary patients in state and private hospitals. The law usually provides that the patient must sign an application for admission, that his mental condition must be such that he can understand the nature of this request as well as the need of treatment, and that he must be released on a demand in writing in from three to seven days of such application. In the case of six of these states his request for

admission must be accompanied by the certificate of one or two physicians, and in some instances his application must be signed in the presence of a physician.

Fifteen states and the District of Columbia have laws authorizing commitment for temporary care and observation. They are Connecticut, Illinois, Maine, Massachusetts, Michigan, Minnesota, New Jersey, New York, North Carolina, Oklahoma, Pennsylvania, South Carolina, Tennessee, Washington, and Wisconsin. Massachusetts has the most elaborate system for temporary care and observation, as is shown by the following provisions:

The superintendent of a state hospital may receive and detain, for not more than five days without a court order, any person whose case is "certified to be one of violent and dangerous insanity or of other emergency" by two qualified medical examiners. Officers authorized to serve a criminal process, or police officers, must, on the request of the applicant or one of the examining physicians, bring such a person to the hospital. (Section 42, Chapter 504, Acts of 1909.) The applicant for this form of admission must within five days arrange for the commitment of the person so received, or for his removal from the hospital.

Under another provision of the Massachusetts law, a person found by two qualified examiners to be in such mental condition that his commitment to a hospital for the insane is necessary for his proper care or observation may be committed to a state hospital "for a period of thirty-five days pending the determination of his insanity." (Chapter 145, Acts of 1919.)

Under the provisions of the so-called "Boston Police Act" (Chapter 307, Acts of 1910), all persons suffering from delirium, mania, mental confusion, delusions or hallucinations, under arrest or "who come under the care or protection of the police of the city of Boston" shall be taken to the Boston Psychopathic Hospital "in the same manner in which persons afflicted with other diseases are taken to a general hospital." Cases suffering from delirium tremens or drunkenness may be refused by the hospital authorities; otherwise, all such persons are admitted, observed, and cared for "until they can be committed or admitted to the hospital or institution appro-

priate in each particular case" unless the patient recovers or is discharged.

Under the provisions of Chapter 394 of the Acts of 1911 (Massachusetts), "no person suffering from insanity, mental derangement, deliriums or mental confusion, except delirium tremens or drunkenness, shall, except in case of emergency, be placed or detained in a lockup, police station, city prison, house of detention, jail, or other penal institution or place for the detention of criminals. If, in case of emergency, any such person is so placed or detained, he shall forthwith be examined by a physician and shall be furnished suitable medical care and nursing and shall not be so detained for more than twelve hours." In Boston these cases are sent to the Psychopathic Hospital. In other parts of the state they are cared for by the board of health of the city or town in question until they can be committed to a state hospital or cared for by relatives or friends.

The superintendent of a state hospital, under the authority of Chapter 174 of the Acts of 1915, "when requested by a physician, by a member of the board of health or a police officer of a city or town, by an agent of the institutions-registration department of the city of Boston, or by a member of the district police 'may' receive and care for in such hospital as a patient, for a period not exceeding ten days, any person who needs immediate care and treatment because of mental derangement other than delirium tremens or drunkenness." Such admissions are received on application in writing filed at the time of the reception of the patient or within twenty-four hours thereafter, and must be discharged or committed within ten days unless they make a request for voluntary care.

It may be interesting to note that the temporary-care enactments have very largely determined the legal status of the cases admitted to the Boston Psychopathic Hospital. During a period of six years, 6,499 cases, 57.5 per cent of all admissions, were committed under the "ten-day" temporary-care act referred to. Nine thousand and seventy-four, or 80.3 per cent, of the total number of admissions during the same period were temporary-care cases of one kind or another. The relative importance numerically of the tem-

porary-care group as compared with the voluntary cases is shown by the fact that the latter constituted 17.6 per cent of 11,289 admissions. It has been customary to limit the hospital residence of temporary-care cases to ten days or less. This has been a purely arbitrary arrangement. At the State Psychopathic Hospital at the University of Michigan, where there have been no time limitations on residence, an analysis of 1,279 admissions shows that 74 per cent of the cases were discharged within three months. Approximately 10 per cent were discharged within two weeks. This would strongly indicate the advisability of extending the period of temporary care to at least thirty days.

The provision of the Massachusetts law for the determination of the mental condition of persons under arrest or held under criminal charges is an excellent one and well worthy of consideration. This is covered by Chapter 46 of the Acts of 1917: "If a person under complaint or indictment for any crime is, at the time appointed for trial or sentence, or at any time prior thereto, found by the court to be insane or in such mental condition that his commitment to a hospital for the insane is necessary for the proper care or observation of such person pending the determination of his insanity, the court may commit him to a state hospital for the insane under such limitations as it may order." The court may in its discretion employ one or more experts to examine such persons. These cases are on recovery returned by the hospital authorities to the custody of the court. One of the interesting features of the Massachusetts law is the provision relating to persons indicted for murder or manslaughter, but acquitted by a jury by reason of insanity. Such cases are committed to a state hospital for life and can be discharged only by the governor of the state with the advice and consent of the executive council, when he is satisfied, after an investigation by the Commission on Mental Diseases, that such a person may be discharged "without danger to others." (Section 104, Chapter 504, Acts of 1909.)

In 1919 the National Committee for Mental Hygiene made an extended study of methods of commitment to institutions for mental diseases. A comprehensive report on this subject was made by a committee consisting of Dr. George M. Kline,

Commissioner, Massachusetts State Department of Mental Diseases; Dr. Charles W. Pilgrim, Chairman of the New York State Hospital Commission; Dr. Owen Copp, Superintendent, Pennsylvania Hospital, Department for Nervous and Mental Diseases; Dr. Frank P. Norbury, of the Board of Public Welfare Commissioners of Illinois; and Dr. Frankwood E. Williams, of the National Committee for Mental Hygiene. In addition to the regular commitments by a court of record in a civil proceeding, they recommended legislation in all states authorizing temporary care, emergency care, observation pending the determination of insanity, and voluntary admissions. In a general way, the legislation proposed was modeled after that of Massachusetts.

THE STATE PSYCHOPATHIC HOSPITAL*

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IN spite of the general interest that has been shown in the subject of psychopathic hospitals by those who are concerned with the care of the mentally disordered, the establishment of this type of institution has progressed but slowly. The experiences of the few hospitals of this type that are already in existence have definitely shown that they have a field of work in which they are accomplishing great good, and that they have developed machinery for meeting aspects of mental disorders in ways not otherwise provided.

Discussions that have centered about the establishment of these hospitals have brought out some differences of opinion as to the type of organization that was desirable and the field of work with which they were to be concerned. In a large measure these differences have had their source in the feelings of necessity to adapt the new organization to local situations, this seeming to be the most practical way to bring about public support. It has, however, usually been appreciated that compromises were being made with the conception of the ideal institution. Thus, there are now in existence psychopathic hospitals, state psychopathic hospitals, psychopathic wards of general hospitals, psychiatric clinics, and psychiatric institutes.

All of these have their distinct values and are meeting their problems in a more or less adequate manner, but the idea must be kept clearly in mind that they are not all equivalent.

The psychopathic hospital, whatever be its title, implies an institution of a definite type of organization and special facilities. As formulated by Dr. Southard in one of his reports, "it is an institution ready to attack within its means all the problems of psychopathology, both practical and theoretical, having in mind the patient of the day and the patient of the future."

*Reprinted through the courtesy of the *American Journal of Insanity*.

A conception such as this can be realized only by an organization having its own special building for the observation and treatment of a limited number of patients. It must be administered by a medical staff of adequate size, specially qualified for psychiatric work. It should have ample laboratory facilities for research and clinical diagnosis, and above all its activities should be dominated by an attitude of keen scientific interest.

Different problems of situation will in a general way determine two types of psychopathic hospitals—one that must adapt itself to the problems of mental disorders as they concern the state as a whole, or the state psychopathic hospital, and one that must adapt itself to the psychiatric problems of a concentrated district, or the municipal psychopathic hospital.

The circumstance that the care of the mentally disordered has always been a problem largely assumed by the state has naturally directed most interest to the state type of hospital. But the field of work that will serve the purposes of the state as a whole will not meet the psychiatric problems that exist in every densely populated community. The density of population, with its complicated social situations, the character of problems that are presented to organizations doing welfare work, those that arise in the schools, and especially in the courts dealing with crime and delinquencies, these and many other problems that have become apparent in the larger cities during recent years require a special type of institution to carry on adequately the functions of a municipal psychopathic hospital.

It is our purpose on this occasion to discuss the organization and activities of the type of institution that in our opinion would best serve the needs of the state as a whole, adapting its field of work to the existing organizations of the state that are now caring for the insane and mentally disordered.

At the present time perhaps the most urgent motive for the development of psychopathic hospitals is to serve as teaching centers for psychiatric training. This bears directly on the problem of the location of the hospital. Psychiatric teaching can be best carried on in as intimate connection with a medical school as possible. Where the state has a

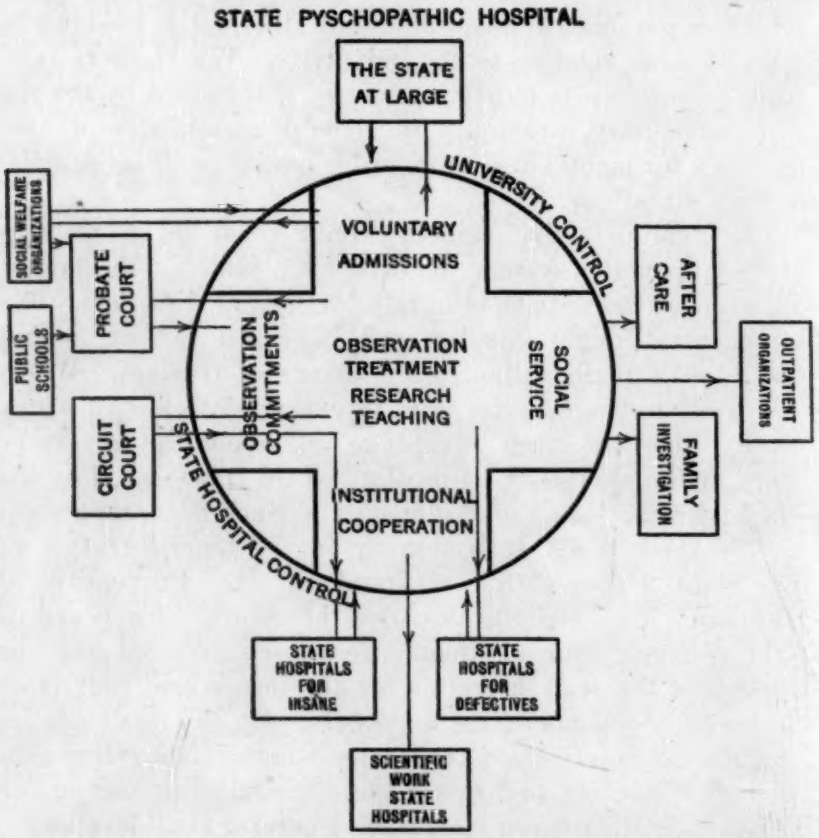
state university and in connection with this a medical school, this obviously should determine its location. While psychiatry should always be regarded as a branch of medicine, there are aspects of the subject that may be taught with much success in connection with the undergraduate courses of a university. Where the state university has no medical school, a psychiatric hospital would still find a most useful place in close relation to the university. Where there is no state university, its location might be determined by the size of a community, proximity to general hospitals or district hospitals for mental disorders, or by special facilities peculiar to state situations.

The administrative control would in a large measure depend upon the system followed by a state in the administration of its district hospitals for mental disorders. The management might equally well be cared for by central boards of administration or by boards of trustees. Where the psychopathic hospital is in intimate relation with a university, there is much advantage in having the governing board of the university or medical school represented on the administrative board of the hospital. Such an arrangement as this works most satisfactorily in the administration of the State Psychopathic Hospital at the University of Michigan. This hospital is under the control of a board of eight trustees, four of whom are chosen from among the trustees of the state hospitals for the insane and four from the board of regents of the university. By this joint administration the interests of the hospital both in its relation to university teaching and to the state organization caring for the mentally disordered may receive careful consideration.

In the plate accompanying this paper I have represented in diagram the organization of a state psychopathic hospital, its relations to the care of patients, and its field of work.

For purposes of discussion, the fundamental activities of the hospital are subdivided among (1) observation, (2) treatment, (3) research, (4) teaching. All of these intimately interlock and all center in the patient. While local circumstances—such as special relations with courts and welfare organizations, relations to general hospitals and medical schools, special types of clinical material, special laboratory

opportunities, or a personnel unusually qualified for special problems—may stress more particularly one of these fundamental divisions of the hospital's interests, it is our personal belief that the state will be rendered best service when these interests are balanced as equally as possible.



One advantage that the psychopathic hospital should have that cannot well be a feature of a district hospital of a state is a degree of flexibility of operation that will allow it to take up special psychiatric problems that may arise at any moment. New avenues for extension of the interest of the hospital will be continually opening up, and the hospital should be ready and easily adjustable to meet any of these.

For carrying on these fundamental activities, the hospital should be provided with all necessary facilities: Its labora-

tories, treatment facilities, teaching rooms, apparatus, and libraries should be adequately equipped and maintained. Unless this is done, the hospital will lack the distinctive features that are one of the chief reasons for its establishment.

The essential purposes of a special hospital for intensive observation and treatment must necessarily limit its capacity. The exact number of beds that the hospital should have is a matter of detail, but the number should be small enough to permit a thorough observation and intensive study of its patients. Its size should be determined by the number of physicians it is practical to maintain on its staff. It is not practical to adjust its size to the demands for admission of patients. These, if the hospital attains success and holds the confidence of the people, will far exceed the ability of a hospital of moderate capacity to care for. It should be sufficiently large to furnish varied clinical material for teaching and to maintain the clinical interests of the staff. According to the size of budget that a state might allow for maintaining a medical staff, its capacity should not be less than fifty beds nor should it much exceed one hundred. The State Psychopathic Hospital at the University of Michigan, with a clinical staff of four full-time physicians, has a capacity of sixty-two beds in which are annually treated about three hundred and twenty-five patients. The smaller the number of beds and the larger the clinical staff, the more do the patients benefit and the more opportunity will be available for research.

The psychopathic hospital is essentially a diagnostic hospital. It should be a hospital in which every facility of proven value should be available for diagnostic aid. As a treatment hospital, its functions must unfortunately be limited, owing to the prolonged course that is usual in severe mental disorders. The length of time required for cure or marked improvement of the psychoses is a matter usually of months and even years. To assume a prolonged treatment of patients and at the same time have a space available to receive all patients that are specifically suitable for a hospital of this type would require a number of beds so large that it would be difficult to manage without a clinical staff of

impractical size. Of the patients at Ann Arbor who recover under treatment in the hospital, 84 per cent recover within three months and 69 per cent of all patients discharged have been in the hospital less than three months.

The limited capacity and special purposes of a psychopathic hospital demand that some selection should be exercised in the type of mental disorders that are to be admitted for examination and treatment.

While the hospital might be of great service to the state if it might act as a clearing house to which all mentally disordered patients who require treatment should be sent for examination, such a plan seems impractical owing to difficulties of transportation and the large number of patients that would require care. There are certain types of mental disorders that the psychopathic hospital is peculiarly suited to care for, and for which the state now makes inadequate provision. These are individuals who are mentally ill, but not to a degree or character to enter the district hospitals of the state. The larger number of such patients are ill with psychoneuroses or are suffering from pathological mental difficulties which interfere with their success in life, but do not require the legal restrictions that commitment to a hospital for the insane necessitates. Such patients come to the attention of physicians, school officers, social workers, general hospitals, and from families who appreciate their mental illness, but hesitate in sending the patient to a hospital for the insane.

There are some special types of definite insane conditions that the psychopathic hospital should receive for diagnosis and treatment. These are patients with mental disorders directly interrelated with physical disease. Disorders such as these require unusual skill and facilities for diagnosis. Their treatment is so largely medical or surgical that they should have the advantages of the special facilities available where a hospital is intimately a part of a general hospital or medical school.

In practice it has been found difficult to limit the admissions to any particular class of patients. When a state hospital offers unusual facilities for examination and treatment, it is but natural that there should be a large demand by

citizens of the state for the admission of those in whom they are personally interested, no matter how unsuitable they may be for treatment in this special type of hospital. As the committing authorities become familiar with the purposes of the hospital, this difficulty will be minimized. There are also advantages in having available a wide range of types of mental disorders for purposes of research and teaching.

The problem of the types of patients that are to be admitted will in a large measure be determined by the points of contact that the hospital establishes with organizations of the state that come into direct relation with individuals with mental difficulties. As a diagnostic hospital, it should as far as possible coöperate intimately with the schools, courts, state institutions, and welfare organizations of the state. It should be possible for these agencies to send to the psychopathic hospital for diagnosis individuals who seem to have mental disorders that may be related to their backwardness and delinquency or social maladjustment. The results of this observation should aid in a proper medical or social treatment.

The legal provisions governing the admission of patients to the hospital should be as free as possible from formalities that may in any way produce social embarrassment for the patient. While undoubtedly legal restraint of some sort is necessary for those who need treatment and yet are unwilling to enter the hospital, or for those who may be a social menace if at large, the aim should be to arrange the conditions for admission so that they may approach as nearly as possible to those in practice for the admission of patients to general hospitals. During the past year 53 per cent of the admissions to the State Psychopathic Hospital at the University of Michigan were voluntary and of these 43 per cent were supported at public expense.

An important field of work for the state psychopathic hospital should be in connection with criminal and juvenile courts. In this they would be of great service in the determination of mental disorders in those accused of crime or delinquency. The extent to which a psychiatric hospital can extend its service into the field of criminology is at present much hampered by formalities and limitations that surround

the administration of the criminal law. There is no more rational approach to the problems that concern the criminal courts than by study of the personality of the individuals they deal with. The needed information can be obtained only by the psychiatric examination. While there are serious difficulties in caring for criminal cases among the general group of patients of a psychopathic hospital, this need not prevent the institution from in some way developing a close coöperation with the courts.

The highly qualified personnel of the medical staff of the psychopathic hospital and its laboratory facilities should place the psychopathic hospital in the position of a state institute for psychiatry. As such, it should have an intimate coöperation with the district state hospitals caring for patients with mental disorders, not only hospitals for the insane, but those for the epileptic and defective. It should be possible for these hospitals to transfer to the state psychopathic hospital such patients as may be expected to benefit by the diagnostic and treatment facilities of that hospital. This coöperation will be needed by reason of the necessity of transferring patients from the psychopathic hospital to these hospitals after a period of observation and treatment. The double interest thus established in the patient would be a helpful means of maintaining this coöperation. About 22 per cent of the patients discharged from the State Psychopathic Hospital at the University of Michigan are transferred directly to a district state hospital and an additional small per cent enter these hospitals after a period at home.

As a central institute coöperating with other state hospitals, there are possibilities of conducting research activities in a most favorable way. In the work of the pathological laboratories, material for study could be furnished by the state hospitals, and the results of this study should be systematically communicated to the respective state hospitals. Such a plan will keep the medical interests of all hospitals at a high standard. Its central relation to the state hospitals caring for the mentally disordered would provide the state with a most useful organization for determining policies dealing with mental disorders and of conducting a unified attack upon these serious problems as they affect the public health.

The laboratories of the hospital could assume diagnostic work not possible in the separate district hospitals. By doing the serological work for these state hospitals it could most effectively unite the interests of all in problems as they affect the state as a whole.

The facilities of the psychopathic hospital should at all times be at the disposal of the state hospitals for mental disorders. For purposes of study, classes for systematic intruction in psychiatry should be arranged for the benefit of the medical assistants of the state hospitals.

This centralizing of laboratory functions need not interfere with the independence of action of the large state hospitals, nor should it limit the field of interests of these institutions. This has not occurred in Michigan, where the psychopathic hospital has at all times had the most cordial coöperation from the other state hospitals.

A most important division of the activities of a psychopathic hospital is one that should be concerned with the social aspects of psychiatric problems. Mental disorders are so frequently interlocked with personal situations of environment, of family and occupational relationships, that the hospital will fall short of its possibilities for the treatment of patients unless it is prepared to deal with these problems. These include both intra- and extramural interests. The intramural social psychiatric work involves studying the social relations of the patient in respect to family, school, and occupational life. Unless this information is available, it is not possible to give adequate treatment to a large proportion of patients seeking aid from the hospital. In this feature of the work of the hospital it is desirable that there be an intimate coöperation between the medical staff and those who are technically trained in psychiatric social work. While the attitude of the hospital toward the patient should always be dominated and directed by a medical point of view, there are some aspects of treatment that can be well cared for by lay workers who are specially trained in the problems of social influences upon personality. If this is recognized by the hospital and adequately provided for, the clinical work will be greatly facilitated.

The interdependence of social relations with problems of

mental health forces upon the hospital the necessity of assuming extramural responsibilities. As a state hospital having the entire state as its field of work, the possibilities for extramural work and social psychiatric service are almost unlimited. The fundamental purpose in the organization of this work should be to extend as far as possible facilities for psychiatric diagnosis and treatment to the citizens of the state. In details and plans of operation this extramural work must be somewhat different from those of the psychopathic hospital of a municipality. This is largely due to the widely scattered and often far distant localities from which patients come to the hospital and to the lack of development of social welfare organizations in the smaller communities.

The hospital should maintain out-patient clinics, traveling field services, and should carry on family investigations that concern the patients they examine and treat. The development of the extramural work at the State Psychopathic Hospital at the University of Michigan has been one of its most useful features. In its local out-patient service in connection with the general hospital of the university, it annually examines over 600 patients, and in its out-patient service in Detroit over 1,200 patients are annually cared for. Plans for future developments include the organization of a traveling psychiatric clinical service that will enable the hospital to extend its facilities to most of the towns and communities of the state.

Not only should the state psychopathic hospital be interested in what directly bears on the treatment of its patients, but its position and facilities should make it the leader in the state in the field of mental hygiene and a force for educating the public regarding whatever is active in impairing the mental health of the citizens of the state. It should be the psychiatric division of the public-health agencies of the state.

The conception of the organization and function of the state psychopathic hospital that we have developed in this discussion is something more than that of a hospital for treatment, research, and teaching in their more restricted meaning. It is that of a state agency to deal with psychiatric problems in their widest relations to the health of the citizens of the state. Its possibilities for practical services will be limited

only by the ability of its administrative personnel and the financial support given to it by the state. It is a new unit of the states' system for caring for the mentally disordered, supplementing the functions of the present state hospitals for the insane and able to coördinate all of the psychiatric activities of the state.

It is to be hoped that there may be a more general recognition of the need of such institutions throughout the country.

A STUDY OF THE ECONOMIC STATUS OF FORTY-ONE PARETIC PATIENTS AND THEIR FAMILIES*

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EXPERIENCE has shown us that the main social difficulties in which the families of patients with general paresis are involved are of an economic nature. The inefficiency, irritability, and peculiarities of the paretic patient often lead to loss of work and to hospitalization. A reshaping of the home and a change in the social and financial arrangements are thus demanded. It seemed worth while to study intensively a group of paretic patients in order to determine just what the social worker and the doctor can expect to encounter in the way of social maladjustments caused by or coördinate with general paresis.

As our interest was in the family, a group was selected along the following lines: Only committed male patients with general paresis, between the ages of twenty and fifty, who were married and had children, were considered. Male committed patients were chosen because we were interested in noting the social effect of syphilis in families from which the main support was withdrawn. The age period represents the best years of a man's life, before which one would not expect him to carry much responsibility and after which his powers might decline without the agency of syphilis. Obviously, the problems of the unmarried are different. Families without children were not included nor those in which the wife was dead, as we wished to study families that were complete except for the committed member. Patients whose families lived out of reach were not studied, as no reliable data could be secured. All inquiries were made by reading of records

* This study was carried on by funds from the Interdepartmental Social Hygiene Board. We wish to express our appreciation to Mrs. Gerna S. Walker for her assistance in the field work and tabulation.

supplemented by home visits to the nearest relative. In 33 of the 41 families, it was possible to interview the wife and secure first-hand information. In the remaining cases, near relatives were interviewed and their stories were supplemented by the history already given in the records.

The main points investigated were:

1. The industrial status of the patient in relation to his disease, emphasizing comparative earnings, types of position, capacity for accomplishment, etc., before and at the acute onset of the disease.
2. The effect of the patient's illness on the wife in the home.
3. The effect on the children.
4. The necessity for familial financial aid.

Let us take up these points one by one.

An examination of the annual earnings of the 41 paretic patients studied shows that we are not dealing with a group normally below the poverty line. Thirty patients were earning over $900 annually for the five years directly preceding the investigation (1914–1919), as shown by the following summary:

Annual earnings *	*Patients*
Under $625	4
$625-$899	5
$900 and over	30
Unknown	2
Total	41

At the time of admission and commitment to a state hospital, when their salaries automatically ceased and new means of support for the family had to be created, 22 patients were still receiving their normal salaries, 9 were at a minimum salary, and 7 at a maximum. Of the 7 cases of maximum salary on admission, 6 were due to inflated war wages and in the seventh case the patient's salary was deliberately increased so that on retirement he could receive a larger pension. This war increase indicates the scarcity of labor, without which probably more patients would have been reduced in

* This summary gives wage earned by patient five years before investigation was made. The grouping of annual earnings follows a similar grouping in a study of infant mortality in Johnstown, Pa., made by the Children's Bureau, 1915.

salary. The fact that the salaries of the majority were unchanged does not mean that their work remained high grade. The cause might be labor conditions such as those just mentioned, length of time in the job, kindness of employers, etc. As a matter of fact, further study shows a decided decline in capacity.

It was possible to obtain information on the ways in which the decline in capacity manifested itself in 27 of the 41 patients. Such descriptive terms of decline were used by relatives as "inefficient," "unreliable," "could not concentrate," "slow," "childish," "tired and took much time off," "irritable and unreasonable," "could not use hands well." It is evident that there is a general mental deterioration manifesting itself in slowness and inefficiency. This decline was slow and insidious in some cases, acute in others. The following summary shows that the decline of the 27 varies from a month to two years and over:

Length of decline	*Patients*
Under 1 month	1
1 to 6 months	7
6 months to 1 year	5
1 to 2 years	5
2 years and over	3
"Few months"	2
"Months"	1
Unknown	3
Total	27

One naturally questions whether these men were thrown out of work because of this inefficiency, whether they changed jobs frequently, or how their economic status was affected. We found that 13 of the 27 had worked for the same firm five years, and an additional 2 for several years before admission, and were kept on because of faithful service. Two patients were in business for themselves and as a result of their incapacity failed. Four had not been in any one's employ for a long period, as they normally changed jobs frequently.

In addition to the above mentioned incapacity, irregularity at work might be a sign of deterioration. Seven of the 41 patients were extremely irregular at work for "a few months to two years" before admission. An additional 12 had held

"many" jobs during the five years before admission. Thus we have a total of 19, or almost one-half, who were irregular at work.

Jobs held during last five years	*Patients*
One	18
Two	6*
Three	2
Four	2
Five	..
Six	1
Unascertained	12
Total	41

The 12 unascertained cases had held many jobs. In 9 of the 12 the frequent change was ascribed to the instability, unreliability, and inefficiency of the patient. It must, however, be kept in mind that many of the patients showed considerable stability. Only 8 of the 41 changed their *type* of work during these five years, 6 to less skilled work and 2 to different work on the same plane. As shown above, 18 had worked for the same firm for the five years previous to hospital admission, and an additional 8 had had two or three jobs. Thus 26 were steady on the job, while 15 had had several jobs. This is shown again by the following outline with emphasis on the length of time in the last job:

Length of time in last job	*Patients*
Under 6 months	8
6 months to 1 year	3
1 to 2 years	3
2 to 3 years	1
3 to 4 years	2
4 to 5 years	2
5 years and over	18
Unknown	4
Total	41

The reasons given for leaving the last job are of interest. Over one-half gave a medical cause. The others could not

* One patient who held two jobs held them both at the same time, one during the day and one in the evening.

keep up in their jobs, and this was recognized by employers and family. The following summary gives in detail the causes assigned for the 41 patients leaving their last job:

Medical cause	*Patients*	*Industrial cause*	*Patients*
Sick	8	Work became poor	4
"An attack"	2	Inefficient	3
Physical incapacity	2	Lack of attention to duties	2
Hands unsteady	2	Accounts confused	1
"Tired and run down"	4	Making mistakes	2
Worried and nervous	1	Forgetful	1
Loss of leg in accident	1	Discouraged	1
Drink	1	Extravagant ideas and plans	1
Shock	2	Delusions concerning fellow workmen	1
Unknown	2		
Total	25	Total	16

The time out of work before admission is of importance in relation to the economic status of the family of the patient with general paresis.

Time out of work before admission	*Patients*
No time	6
Under 1 month	15
1 to 6 months	13
6 months to 1 year	3
1 year and over	2
Unknown	2
Total	41

This summary shows that the large majority, though often inefficient at work for a long period, as shown on page 558, were actually out of work only from a few days to six months. This, together with the small decline in wages, would indicate that although actually the patient has been an increasingly incapable person, the income of the family is not usually markedly diminished for a long period before commitment. The family was usually able to get along during these months, but the seriousness of the strain is felt when the savings are eaten up simultaneously with the commitment of the wage earner. Something must then be done at once to replenish the family finances.

This brings us to our second point, the effect of the

patient's commitment on the wife. Eighteen of the wives went to work because of the patient's illness—12 full time and 6 part time, 14 outside the home and 4 at home. Those working outside the home did work varying from washing, ironing, and cleaning to factory and office jobs. Those who remained at home earned their living by sewing or taking lodgers and boarders.

The wages earned by these wives are shown in the following summary:

Part time	*Wives*
$2 a week	1
$7.50 a week	1
$8 a week	1
$10 a week	1
$12 a week	1
$14 a week	1
Total	6

Full time	*Wives*
$12 a week	1
$13 a week	2
$13.50 a week	1
$15 a week	2
$16 a week	2
$18 a week	2
$21 a week	1
$35 a month with keep for self and child	1
Total	12

Outside home	*Wives*
$2 a week	1
$7.50 a week	1
$8 a week	1
$10 a week	1
$12 a week	2
$13 a week	1
$13.50 a week	1
$15 a week	1
$16 a week	1
$18 a week	2
$21 a week	1
$35 a month with keep for self and child	1
Total	14

At home	*Wives*
$13 a week	1
$14 a week	1
$15 a week	1
$16 a week	1
Total	4

In addition to the fact that these 18 wives had to undertake the burden of aiding in the support of the home, we are confronted with our third point—namely, the direct effect on the children. There were 108 children in these 41 families, 75 per cent of whom were under fourteen. The children whose mothers worked at home would not feel anything

direct, but rather a little less physical and mental care. There were, however, 39 children of the 14 mothers who worked outside the home.

Of the 22 children of the mothers who worked full time outside the home, 6 were under the age of six, 10 between six and fourteen years, 2 between fourteen and sixteen years, and 4 sixteen years or over. Of these children, 12 were male and 10 were female. Of the 17 children of those mothers who worked part time outside of the home, 5 were under six years, 9 between six and fourteen years, 1 between fourteen and sixteen years, and 2 sixteen years or over. Of these children 8 were males and 9 females.

Thirty of these children were under fourteen, 11 under six. Although many of them needed a mother's care, a number were left alone and some were placed out, but the burden of care in most cases was transferred to other relatives. In this group of 14 families, two children worked, the "children" being a man of twenty-five and a girl of sixteen; hence there was no social difficulty. Two of the children left alone were old enough to be able to care for themselves. One child of eight was alone all day except when in school and was locked out of the tenement until her mother returned from a day's work. In a family of six who were alone while the mother worked from six to nine every evening, children of ten, nine, seven, five, and three were left in the charge of a twelve-year-old girl.

Inquiry into the question of whether the children are at work because of the illness of their father showed that there was no increase in child labor. There were no children working under fourteen years of age, 2 between the ages of fourteen and sixteen, and 6 at sixteen years or over. These 8 children were members of 5 of the 41 families.

There were in addition a few young people who before the illness merely added to the family income, but who thereafter became the sole support of the family. In one case a daughter of eighteen, in another two sons of seventeen and sixteen, carried the burden of family support.

In 3 families 11 children, or one-tenth of the total children, were placed out. Most of these placements were made by

private charitable institutions. This leads to the question of financial aid, which was received by 27 families. Permanent aid was necessary in 26 families. This aid was given in 13 cases by public agencies, in 5 by private agencies, and in the remaining 8 by relatives. One additional family needed temporary aid only. These figures represent the status at the time of the investigation, when the patient had been committed some time. If we include the rather prolonged temporary aid in two additional families, we have 28, or over two-thirds, of the families who were aided at one time or another more or less permanently.

Aid was received from two sources in 8 families. In most of these the supplementary aid was given by the wife's family. In other cases in which aid was received, the mother worked full or part time in addition. The entire support of the 41 families at the time of investigation is shown in the following table:

NO OUTSIDE AID

Support	*Families*
Wife	7
Wife's family	6
Wife and wife's family	3
Children	2
Wife and daughter	2
Wife and son	2
Wife and patient	1
Unknown	1
Total	24

PUBLIC AID

Support	*Families*
Public aid	2
Public aid and wife's family	5
Public aid and wife	4
Public aid and children	2
Total	13

PRIVATE AID

Support	*Families*
Private aid	1
Private aid and wife's family	2
Private aid and children	1
Total	4

The following summary shows a comparison between the family income at the time of the investigation and at the time the patient left work:

	Number
Income when patient left work—smaller	9
Income when patient left work—larger	23
No present income—supported by wife's family	7
Unascertained	2
Total	41

In 30 of the 41 families, the family income at the time of the investigation was less than when the patient left work. This indicates a general decline in the standard of living.

To summarize, then, in a normally self-supporting group of families, the entrance of paresis had the following effects:

1. Over one-half of the patients were receiving normal salaries at the time of admission to a state hospital.
2. Between one-half and three-fourths, however, showed a decline in working capacity.
3. This decline varied from one month to two years.
4. In spite of this decline, most of the patients were not discharged, especially by firms with whom they had worked for years.
5. Almost one-half were irregular at work or changed jobs frequently, but only a few changed to less skilled labor.
6. Over one-half gave a medical cause for finally leaving work, while the others gave an industrial cause.
7. Very few were out of work for a long time before admission.
8. Although the wages were not markedly decreased nor the patient out of work for a long time before admission, the eating up of savings followed by the sudden cutting off of the income shows that a little less than one-half of the wives went to work because of the patient's illness, three-fourths of them working outside the home.
9. Of 39 children whose mothers worked outside the home, 30 were under fourteen and had to be cared for by other relatives.
10. There was no increase in the number of children working, though some children already working had to assume heavier burdens than normally.

11. Only a few families were forced to place out children.

12. Two-thirds of the families received permanent aid because of the commitment of the patient. This aid was from public and private agencies and relatives.

13. At the time of the investigation, almost three-fourths of the families had less income than when the patient left work.

RECORDS AND STATISTICS IN OCCUPATIONAL THERAPY *

HORATIO M. POLLOCK, PH.D.
Statistician, New York State Hospital Commission

OCCUPATIONAL therapy is passing through a transition stage. From an incidental, unorganized activity of our state hospitals, it is developing into an elaborate agency for the restoration or improvement of disordered minds. Our best institutions for the insane are now schools as well as hospitals, and it is believed that in the days to come the school will constitute the leading remedial factor of these institutions. Improvement of methods and broadening of scope are going hand in hand in occupational therapy. The subject matter of the new science is being tested, and experiments in various states are being keenly watched.

Much of this advance in occupational therapy is due to the careful study and painstaking thought of our honored president, Mrs. Slagle. Her great service to the Illinois hospitals is an inspiration to occupational teachers throughout the country.

The active interest and progress in this field naturally cause a demand for accurate data concerning operations and results. Unfortunately no adequate accounting of the work thus far done in occupational therapy has been made. There are some good records here and there, but very few of them are available for public use.

Now, since the state hospitals for the insane throughout the country have adopted a uniform classification of mental disorders and a uniform system of statistics relative to admissions, discharges, and deaths, the way is open for a system of uniform records and statistics in occupational therapy. Much would be gained from such a system, and as most hospitals have not yet established satisfactory records in this branch of their work, it would be easy for this associa-

* Address given at the annual meeting of the Society for the Promotion of Occupational Therapy in Philadelphia, September 13, 1920.

tion to secure the general adoption of any system of records or statistics that it deems satisfactory.

In attempting to formulate a system of records or statistics, we naturally ask the purpose to be attained. Why do we need records and statistics in occupational therapy? If there is no real need for such records, we should not advocate their use. Unused and unnecessary records already crowd our hospital files, and no one wishes to add to the number.

In this work, however, certain records are as necessary as entries in a check book. If we leave everything to memory, our working balance will soon be a very uncertain or perhaps a minus quantity. We cannot possibly remember all we need to know concerning our pupils. We need records, therefore, for our own guidance.

We must also remember that we are working for others; the relatives of our patients, the hospital physicians, the superintendent, and the people of the state itself, all have an interest in our work, and we should be prepared at all times to give an accurate account of what we are doing and what we have done during preceding years.

We must go a step further. We are not servants of the present day alone, but future days and years, if not ages, need us, and we can render valuable service to others in the future as well as the present by making definite records of our accomplishments and also of our failures. Our recorded successes will point the way for others to go, while our recorded failures will show the paths to be avoided. By carefully analyzing the results of our work year by year and by comparing them with the achievements of others, we shall make rapid progress and ultimately a firm scientific basis for our work will be established.

In attempting to formulate a system of records that will fulfill the purposes outlined, I have tried to observe the principle that records should be simple, easily kept, give desired information, and constitute a harmonious system. All of the entries made must serve a purpose and be used; otherwise much waste effort will result, and the records will be poorly made.

I would recommend that four forms be used in making records in occupational therapy—namely, a prescription card,

an administrative card, a class-attendance register, and a yearly statistical card. A draft of each of these forms is submitted as an appendix to this paper.

The prescription card is to be made out by the physician in charge of the patient before the patient enters a class. This presupposes a thorough knowledge of occupational therapy on the part of the physician. While the physician, as the superior officer, must direct the work, the best results will often be obtained when the prescriptions are made out after consultation with the head teacher of occupational therapy. The progress of the patient must be carefully watched, and the prescription changed as often as necessary.

The prescription card would give the name of the patient, the sex, age, diagnosis, physical diseases or defects, physical condition, mental condition, previous vocation, special aptitudes and interests, the kind of occupation needed, the frequency of rest and exercise periods, and any special instructions the physician desires to give. These data are all necessary in order that the teacher of occupational therapy may thoroughly understand the patients who enter her class.

When the patient is turned over to the teacher of occupational therapy, an individual administrative card would be made out. This would contain important reference data taken from the prescription card and would provide for a monthly record of the attendance and progress of the patient for a period of two years. Special notes concerning the patient could be entered on the back of this card. The card would be kept for ready reference in an alphabetical index file in the office of the head teacher.

The register of attendance would be kept by the classroom teacher. It would provide for a complete record of the attendance, kind of work, and progress of each member of the class for a period of one month. At the end of the month the record would be handed to the head teacher and entries therefrom would be made by a clerk on the administrative cards.

The statistical card would be made out for each patient taught in the occupational-therapy classes during the year. The data for the preparation of this card would be obtained from the administrative card and from the examination of the patient at the end of the year. The card would show the

mental and physical condition of the patient at the beginning of the instruction, the kinds of instruction given, the length of time of each, and the results obtained. These cards would be used for the purpose of analyzing the results of the year, and statistical tables would be prepared therefrom. Such tables could be few or many, as desired. Those recommended for general use in state hospitals for mental diseases are:

1. Class attendance and disposal of patients classified by sex and psychosis.
2. Progress in graded work of patients classified by sex and psychosis.
3. Change in mental condition of patients classified by sex and psychosis.
4. Kinds of work and results obtained in principal groups of psychoses.

The statistics thus prepared would give definite answers to many questions concerning which no data at present are available.

The system herein outlined is submitted as a basis for the discussion of this important matter; when perfected, its general use would throw light on many obscure problems and would add greatly to the dignity and efficiency of the work in which we are engaged.

PRESCRIPTION FOR OCCUPATIONAL THERAPY

WARD DATE

NAME OF PATIENT IDEN. NO. SEX AGE

DIAGNOSIS RACE

PHYSICAL DISEASES OR DEFECTS

PHYSICAL CONDITION

MENTAL CONDITION

PREVIOUS VOCATION

SPECIAL APTITUDES OR INTERESTS

TYPE OF OCCUPATION PRESCRIBED

DURATION

REST PERIODS

EXERCISES, GAMES, FOLK DANCING

SPECIAL INSTRUCTIONS

Signature of Physician

(Form 5" x 8", to be printed on heavy book paper and padded)

ADMINISTRATIVE CARD—OCCUPATIONAL THERAPY

NAME IDEN. NO. SEX WARD

DIAGNOSIS RACE

DATE OF ADMISSION 19 PREVIOUS VOCATION

At commencement of instruction:

DATE 19 AGE years

PHYSICAL DISEASES OR DEFECTS

PHYSICAL CONDITION HEIGHT ft. in. WEIGHT lbs.

MENTAL CONDITION

RECORD OF INSTRUCTION

Mo.	Work		Attendance	Progress	Mo.	Work		Attendance	Progress
	Grade	Kind				Grade	Kind		

(Notes on back of card) (Card 5″ x 8″)

OCCUPATIONAL THERAPY REGISTER

Class No. Classroom Teacher

Grade Kind of work

Record of attendance for month ending 19

Name of Patient	Iden. No.	Work		Attendance																																	Progress
		Grade	Kind	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total		

(Form 11" x 14", to be ruled)

MALE OR FEMALE

OCCUPATIONAL THERAPY

_____HOSPITAL

NAME IDEN. NO.

PSYCHOSIS No. Group Type

DATE OF ADMISSION OCCUPATION PREVIOUS TO ADMISSION

AT COMMENCEMENT OF INSTRUCTION

DATE 19 AGE OF PATIENT years

MENTAL CONDITION OF PATIENT: Negativistic apathetic depressed demented flighty over-active paranoic irritable tractable other conditions (specify)

PHYSICAL CONDITION: Weight lbs. (Normal weight lbs.) DISEASES OR DEFECTS (specify)

INSTRUCTION

(Kinds and time each kind was given during year)

RESULT AT END OF YEAR OR AT TIME OF PAROLE OR DISCHARGE OF PATIENT

MENTAL CONDITION COMPARED WITH THAT AT COMMENCEMENT OF INSTRUCTION:

[Show how each abnormal mental condition present at beginning of year has changed by writing after terms denoting condition the letters R (recovered) I (improved) UN (unimproved) or W (worse) as they may apply.]

PHYSICAL CONDITION: Weight lbs. DISEASES OR DEFECTS:

DATE OF BECOMING AN INDUSTRIAL WORKER 19

DATE OF PAROLE 19

DATE OF DISCHARGE 19

DATE OF DISCONTINUANCE OF CLASS WORK AND CAUSE 19 (Form 5" x 8")

OUTLINE FOR A STATE SOCIETY OF MENTAL HYGIENE

E. STANLEY ABBOT, M.D.
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WHEN an otherwise intelligent lady can remark that she doesn't "believe in mental hygiene; it is better to let the insane and feebleminded die out and not be kept alive by mental hygiene to propagate their kind," one can at least infer what some of the activities of the mental-hygiene society in her state have been. Such a remark shows also the need for a fuller and more widespread knowledge of what mental hygiene means and is.

Hygiene in general is concerned, through sanitation, with environments that make for health and, through personal hygiene, with the body, that it may have healthy growth and development.

Similarly, mental hygiene must be concerned with what we may call mental sanitation, both of the environment and of the person. It embraces, therefore, the mental and moral atmosphere into which the young are born, in which they grow up, and in which the adult has to live, and it seeks to keep this atmosphere clean and wholesome. As a matter of personal mental hygiene, it seeks the development of wholesome mental states, reaction types, and adjustment habits of the human being, whether infant, child, or grown-up.

Hence, even before the birth of the child, mental hygiene has its place in the prenatal clinic, to insure that the expectant mother—and the father, too—knows how to create and preserve the best atmosphere for the baby to be born into. This is especially important in the case of the unwilling or the unmarried mother and the unwelcome child.

Health centers and health councils need to be able to teach those—whether parents, other relatives, foster parents,

* Read before the Mental Hygiene Division of the National Conference of Social Work, New Orleans, April 21, 1920.

nursemaids, nurses, governesses, or the officials and employees of child-caring agencies—who care for infants, toddlers, and those of pre-school age how to keep this atmosphere clean and wholesome, free from harmful mental contagions, in order that the right attitudes and habits may be developed during these most formative and impressionable years.

It need hardly be mentioned, of course, that the public schools, with their opportunities, not only in the school itself, but often in the home, for applying the principles of mental health to all the childhood and adolescence of the land, constitute a wonderfully rich field for mental-hygiene effort. For there lies the opportunity, not only for fostering normal psychic health—what we may term ortho-psychics—but for the discovery, prevention, and correction of much undesirable mental development.

All the child-caring agencies have their mental-health problems, based on their obligation to secure for their charges such *mental,* as well as physical, surroundings as will best promote a normal, healthy development. Thus mental-hygiene interest invades this field of work.

Neither the external conditions that foster mental health nor the individual's habits of reacting can be so completely guided and controlled after school years as they can be before and during them. Nevertheless, mental hygiene is finding a field in industry, where not only can it help in vocational guidance and occupational placement, in detecting the trouble maker before he makes trouble—perhaps so guiding him that he ceases to be even a potential trouble maker—and in research as to conditions that may prevent or cause fatigue and other states that affect the psychic factors of the worker, but it may also deal with the relations between the foreman or boss on the one hand and the workman under him on the other, between employer and employed, and with other industrial relations. It may thus become one of the agencies that help to remove causes of ill-feeling, resentment, and discontent, and hence of industrial unrest.

In the field of *prevention* of *morbid* or *ineffective mental reactions,* the public schools again offer a most far-reaching and important opportunity through the introduction of special classes—the adjustment or fitting or opportunity

classes, as they are sometimes called. In these some of the backward can be brought up to normal level, the dullards kept from discouragement by being set tasks within their capacities, the precocious advanced as fast as is compatible with their abilities and strength, and the nervous, peculiar, or difficult child receive special attention, guidance, and direction.

In order that the teachers in public schools may have the requisite knowledge to create the right atmosphere and to teach and train the pupils in wholesome mental habits and reactions, it is necessary that mental hygiene should be taught in the schools for prospective teachers—i. e., in normal schools and colleges. Hence the mental-hygiene movement is concerned to that extent with the curriculum of these institutions.

In order that the children in the schools may be carefully examined, that their education may be fitted to their individual capacities and needs, psychologists are needed to make and interpret the necessary tests or examinations. They are needed to make researches into the mental-health needs of children at different age levels, from infancy onward. In the late school years and in industrial life, vocational guidance and occupational placement and adjustment call for the psychologist's help. Hence a mental-hygiene program may well include an interest in the adequate training and supply of psychologists and the application of their services in these fields of applied psychology.

The *discovery* and *recognition* of *morbid* mental tendencies, reactions, and conditions of persons in home, school, shop, or factory, in penal, correctional, and charitable institutions and other places of relief or detention, and in the community at large are problems of mental medicine, solvable largely by means of mental clinics and by surveys of institutions and communities. Hence the establishment of such clinics in sufficient numbers and accessibility, the conducting of surveys, and the finding of physicians and others capable of conducting them become mental-hygiene interests.

The number of physicians with a requisite knowledge of the mental factors in disease and social maladjustments, who can conduct such clinics, make such surveys, give sound advice, and conduct or guide the various types of institutions, is very limited. To increase their number, to stimulate the study

of mental hygiene and mental diseases, and to increase the facilities in the medical schools and hospitals for research and teaching in these fields are very important from the standpoint of mental hygiene.

The *care* accorded to the persons found by these investigations to have mental disease or defect or other mental handicap has been from the beginning of the movement a chief concern of those interested in mental hygiene. In this connection one thinks first of hospitals for the insane and the feeble-minded, for the epileptic, inebriate, and drug addict. But all types of penal and reformatory institutions, almshouses, and other places of detention should equally be thought of.

One should also think of the large group—many of its members not in hospitals—of discharged soldiers, sailors, and marines who have nervous or mental disease or defect, for whom the government holds itself responsible.

This care involves (1) the mental atmosphere—i. e., the external conditions as they affect the patient mentally—in which the patient is to be, and (2) the medical treatment and guidance of the patient.

1. The mental atmosphere is affected by (a) the laws concerning the general organization of care; concerning the supervision, control, and care of dependents; concerning commitment and admission to, detention in, and release from institutions; concerning the length and character of sentences and commitments; concerning conditions of confinement and opportunity for instruction, labor, and other occupations in prisons and other institutions; concerning appropriations for maintenance and for increased accommodations in all types of institutions.

(b) The structure of the institution, its location and general adaptability to the purposes it is called upon to serve—especially in relation to the proper classification of inmates, that their associates may not be harmful to them—affect the atmosphere in which the inmates live.

(c) The spirit and attitude of the individuals in charge of the prisoners or patients—from the board of managers, the superintendent or warden down to the ward attendant or "keeper"—are of grave importance. These may be such as to

elicit in the inmate reactions that are socially or medically harmful or they may elicit the best.

(d) The whole atmosphere of the institution will be better if it is a place for research and teaching in the field of the disabilities for the care of which the institution was established. For this reason, as well as for the advancement of knowledge of the mental factors in all forms of social maladjustment and of the conditions and causes that determine them, mental hygienists are interested in this educational function of institutions.

2. With regard to medical treatment and guidance, good care requires (a) that there shall be a sufficient number of physicians, nurses, and attendants and that they shall have the requisite degree of knowledge for taking proper care of the patients; and that the institution shall have adequate equipment for administering whatever kinds of treatment, including occupations, are best suited to the needs of the patient. These are naturally items with which mental hygienists are concerned.

(b) Enough hospitals and institutions of all types to meet the mental-hygiene needs of the community are a great consideration. Psychopathic hospitals, psychopathic wards in general hospitals, out-patient mental clinics in general hospitals, special hospitals, schools, and other places, and traveling mental clinics are some of the agencies that it is part of the effort of the mental-hygiene movement to advocate.

(c) The establishment of facilities for after-care, help in resumption of normal life in the community, and guidance in prevention of recurrences of disability fall within the scope of mental hygiene. Social-service workers who have had experience with mental cases and mental out-patient clinics, whether organized by the institution or by community effort quite independently of any special institution for the care of mental cases, are agents to accomplish these ends.

Since social-service workers in general, and especially those who assist in school, hospital, or community mental clinics, are constantly faced with problems into which mental factors enter largely, it is one of the interests of mental hygienists to see that they receive instruction in the nature of these factors and their influence and bearing on their prob-

lems and in the best ways of applying this knowledge in the care of the patient or case.

Thus, to sum up, mental hygiene touches or includes within its field of interest all human activities into which a mental factor enters. It is interested in *environments,* that they may be wholesome and exert a good influence upon the development of right mental attitudes and habits and upon the correction of wrong ones; in *persons,* that they may have the best surroundings and develop and preserve or regain the most healthful types and habits of mental reaction; and in *institutions* and *agencies,* that they may carry on investigations and researches, provide the best guidance and aid in improving environment, and teach, train, and help individuals.

Interest alone in these matters is not enough.

Interest cannot be made effective without an organization of effort. The organization, whether state-wide or local, must be coöperative and must include representatives of the various associations or agencies whose special interests are touched by those of mental hygiene. It must include also other persons possessed of public spirit, social insight, influence in the community, and at least some "visible means of support" for the society.

In Pennsylvania this organization takes the form of one committee in an association whose object is to help advance and improve all public-welfare agencies in the state. It is planned that each of the main groups of public charges—such as dependent children, prisoners, the aged and infirm, etc.—shall have its special committee of the association.

Thus far the Mental Hygiene Committee is the only one that is fully organized, with a paid director, etc.

The Mental Hygiene Committee consists of a large body of citizens resident in various parts of the state. A small executive committee, composed of persons representing the main fields that it is desired to reach, has been formed. Psychiatry, neurology, general medicine, the feebleminded in institutions, the children needing special-class instruction, the delinquents, the social worker, the Red Cross, and the general public are represented on our executive committee of nine.

Owing to special opportunities within the state, the estab-

lishment of special classes in the public schools has been for a year or more an especially desirable object for which to work, and a subcommittee is authorized, with one assistant director in charge of its work.

The state is large and has many separate communities of considerable size, rather widely separated. It is planned to form local committees in these communities, in order that there may be a more widespread and better informed public opinion in matters of mental-hygiene interest throughout the state.

In order to arouse the interest and secure the coöperation of the persons who should be drawn into such a movement in a given community, some few—not too many, two or three—projects of local interest should be selected, for most public-spirited persons active in good works like a definite, concrete object upon which to work or to which to contribute. Such objects will differ in the different communities, varying with local conditions, needs, and opportunities.

Any local problem can be shown to have its state-wide bearings, and any general object can be shown to have its local application.

In order to keep the larger aims and objects of the society or committee before the eyes of present and prospective members, to indicate the general modes of action, and to define certain general principles or policies that should actuate or guide the society, a scheme or outline of these subjects will be of help.

Such an outline should include, not only the general scope of mental hygiene itself, but the needs and opportunities local to the state or the smaller community as well.

Several outlines have been prepared by the various state societies since the mental-hygiene movement started, some very brief, not pretending to cover the whole field, others more fully elaborated. Besides these schematic outlines, there have been some excellent addresses and papers, notably those by Dr. Lewellys F. Barker of Johns Hopkins University, Dr. William A. White of Washington, Professor William H. Burnham of Clark University, and Mr. Clifford W. Beers, founder of the movement.

The outline that we have drawn up in Pennsylvania is the result of composite effort. It was begun two or three years ago by Mr. Kenneth Pray, Secretary of the Public Charities Association of Pennsylvania, and has undergone several revisions since. This latest revision, presented herewith, is not regarded as final. As new insight and experience are gained, it will continue to be modified. It is offered to you now in the hope that it may be helpful to any of you who are contemplating the organization of a mental-hygiene society or committee.

Mental Hygiene Committee of the Public Charities Association of Pennsylvania: Its Objects, Scope, Functions, and Methods

I. General Object

To work for the promotion, conservation, and restoration of mental health. The *promotion* of mental health involves securing a wholesome mental atmosphere in which to live, and training in wholesome ways of thinking and feeling as guides to action; the *conservation* of mental health involves the detection and prevention, and the *restoration* of mental health the relief and cure, of mental diseases, mental defects, and other mental handicaps.

II. Specific Purposes

1. *Research,* to promote the study of the conditions that contribute to wholesome mental activities and the study of mental disease and mental defect in all their forms and relations, and of mental factors in social maladjustments.

2. *Education,* to spread a knowledge of the conditions that foster normal mental development and health; to obtain and disseminate reliable information as to the nature, origin, and effects of mental diseases and defects and the mental elements in anti- and asocial behavior, the prevalence of these diseases and defects in the community, their relations to other social problems, effective methods of combating them, and the work now being done in Pennsylvania in these directions.

3. *Constructive service,* to coöperate with all agencies—such as schools, health councils, etc—that work for normal mental health; to coöperate with, and bring into effective coöperation with one another, all existing agencies in Pennsylvania that deal, directly or indirectly, with mental disease or mental defect or with mental factors of social maladjustments.

4. *Application of these activities to prevention,* to promote the introduction of normal mental-hygiene teaching, training, and practice into the schools and health centers and councils; to disseminate a knowledge of mental-hygiene principles among parents, teachers, and others, in order to avoid the incidence of harmful experiences and complexes in the life of the normal child, and thus to prevent the later possible development of psychoneuroses, etc.; to foster reasonable and unprejudiced attitudes toward government, work, capital, industrial unrest, race riots, and other mass antisocial activities; so to take care of de-

fectives in their earlier years that they will not develop vagrancy, prostitution, criminality, and other forms of dependency; and to stimulate communities to eradicate the venereal, alcohol, and other drug perils and other known causes and conditions that engender mental disease or defect.

III. Organization

1. *A central, state-wide committee*, with a paid director, the committee to be composed of representative citizens in different parts of the state and those who, because of special training, experience, or professional position have special knowledge of, or interest in, mental-hygiene problems.

2. *Local branch committees*, in every important community, each to consist of the members of the state committee who reside in that community, together with other public-spirited citizens who appreciate the importance of the problems and who desire to coöperate in solving them.

IV. Methods

1. *Research*. As occasion warrants and the finances of the committee permit, surveys and investigations will be encouraged or undertaken, as to

a. The main facts underlying the problem in Pennsylvania;

b. Conditions peculiar to Pennsylvania;

c. The work now being done along mental-hygiene lines in this state;

d. Methods in use elsewhere that could be profitably applied in this state.

2. *Educational publicity*, through newspapers, magazines, pamphlets, reprints, reports, news bulletins, lectures, exhibits, etc., with the object of

a. Defining and describing the problem as it exists;

b. Arousing public opinion as to its importance;

c. Acquainting citizens and taxpayers with the difficulties and opportunities confronting those who are dealing officially with the problem;

d. Disseminating information as to means within the power of the individual for combating mental weakness, as to the social evils that foster mental disorders, as to the methods that can and must be employed by the community as a whole to check and control these disorders;

e. Organizing and vitalizing sentiment in support of a sound legislative and administrative policy with respect to mental hygiene.

3. *Constructive coöperation*, through consultations with superintendents and managers of institutions and with other public authorities, through visits to institutions, and through correspondence and conference with social agencies and individuals that are dealing with, or are directly affected by, mental-health problems, with the objects of

a. Helping to introduce concepts and standards of normal mental health into schools and health centers and councils;

b. Helping to raise standards of care and treatment of mental patients in institutions;

c. Helping to obtain public support, moral and financial, for needed improvements and extensions of institutions and agencies dealing with mental patients;

d. Encouraging the full and effective coöperation of institutions caring for mental patients with other social agencies, public and private, and vice versa;

e. Encouraging and assisting these institutions to reach out into the community with preventive, educational, and social service.

V. Policies for Which the Committee Stands

1. *Promotion of normal mental health throughout the state by*

a. Creating local committees on mental hygiene throughout the state, especially in connection with health centers and health councils;

b. Promoting instruction in mental hygiene to prospective teachers;

c. Promoting training and practice in mental-hygiene principles by teachers and pupils in the public schools.

2. *Systematic efforts by the state to prevent an increase of mental disease and mental defect and other mental handicaps, through the*

a. Extension of facilities for early and authoritative diagnosis and treatment of those liable to mental disorders and of mental defectives in childhood;

b. Rapid increase of provision for the discovery, observation, treatment, training, and segregation of all who are now a menace to themselves or to the community because of their mental condition;

c. Stimulation of medical research and scientific social investigations in connection with state institutions;

d. Extension of after-care through state supervision over those who have been discharged from institutions, or whose mental disorder is not so grave as to require permanent custodial care.

3. *The highest possible standards of care and treatment* of all those in Pennsylvania who are suffering from mental handicaps, in order that as many as possible of these unfortunates may be relieved or cured, that all may have an equal chance to profit by the most humane and most enlightened treatment, and that all may be made as comfortable and happy as possible.

VI. Points of View

1. *The Insane or Mentally Diseased*

a. So-called insanity is a disease, requiring for its proper treatment the facilities of a well-equipped hospital and in addition many special appliances.

b. This being a medical problem, the mentally ill should be under the direction of a physician of the highest type, trained in the diagnosis and treatment of mental diseases, familiar with the results of modern research and practice in that specialty. He should be surrounded by an adequate staff of physicians, nurses, and attendants, carefully selected and trained for their special tasks.

c. Every hospital for mental illness should be so constructed and managed as to permit of extended classification and reclassification of the patients, diversified instruction, recreation, and employment, for both therapeutic and humanitarian reasons, and constant individual treatment of all who can respond in any measure to such personal attentions.

d. Every hospital for mental diseases should be a center of research and of teaching. For it is in the hospital that the material for both study and instruction is gathered. Laboratories, equipment, and personnel should be adequate for these purposes. The subjects of research should be, not only physical conditions, but also clinical manifestations in the mental fields, the nature, causes, developments, and consequences of abnormal or inadequate mental processes. Instructions should be given not only to members of its own staff, but to the physicians and others in the community from which the hospital draws its patients.

e. Many forms of mental disease—including fully a third, perhaps half, of all cases admitted to institutions—are due to preventable causes, some of which are within the control of the individual and others within the control of the community. Removal of such causes, prompt identification of early symptoms, and the earliest possible advice and treatment, will be effective measures of prevention.

f. While mental disease, as such, is probably not transmissible from parent to child, the constitutional weaknesses out of which insanity arises may be transmitted. It is the duty of the present generation, therefore, to combat directly, energetically, and systematically those sources of mental disorder that are controllable, in whole or in part, by the individual or the community.

2. *The Feebleminded or Mentally Defective*

a. Feeblemindedness, being due to a defect or lack in the brain as distinguished from a disease, is in most cases permanent and incurable. Those suffering from mental defect in this sense do not "grow up" mentally; they remain as little children. They require, therefore, for proper treatment, long and patient training, careful, constant guidance, and permanent supervision.

b. Since, however, mental defect is fundamentally due to physical defects of the brain structure, and since some forms of mental backwardness are closely related to physical conditions, the feebleminded, like the insane, should be under the direction of a specially qualified physician, who will aim to remove every physical obstacle to mental progress.

c. In institutions for the feebleminded, as in hospitals for the insane, the directing physician should have an adequate staff of carefully selected and thoroughly trained physicians, nurses, and attendants, together with a corps of specially qualified teachers and vocational directors. Research and teaching, as in hospitals for mental diseases, should be acknowledged functions of these institutions. In addition to the best of bodily care and comfort, every child in such an institution should have opportunities for mental training up to the limit of his capacity, supervised recreation, vocational instruction, and productive occupation, so diversified in character as to be adapted to the individual needs and capacities of each child in the institution.

d. Every such institution should be so planned and constructed as to permit of extended classification and reclassification of the dependents, with the object of giving to each the largest possible chance to develop to the greatest degree his potential capacities.

e. Despite this most thorough and enlightened treatment, a large number of the feebleminded will always lack the capacity to manage their own affairs with prudence and to perform their duties to society, and must, therefore, remain permanently under the care of the state, in suitable institutions.

f. A smaller number, having profited by the training given them by the state, either in institutions or in special classes in the public schools, may safely be permitted to live in the community. For these, too, the state must accept permanent responsibility. Through special departments of the state institutions, or through the board of public charities, or otherwise, the state must reach out a guiding, restraining, and protecting hand to help these weaklings meet the temptations and competition of the great world, and must effectually prevent the propagation of defectives.

3. *Other Mental Deviates*

a. Finally, recognizing the close relationship between mentally abnormal and antisocial conduct—as in the problems of pauperism, vice, crime, illegitimacy, neglected childhood, alcoholism, etc.—the state must provide simple, but complete machinery by which the mental factor may be promptly identified in any case and scientifically and effectively dealt with. The whole health, educational, charitable, and reformatory systems of the state must be so organized as to leave no gap where the mentally abnormal or subnormal citizen is left without the oversight, guidance, and treatment adapted to his peculiar needs.

VII. Special Recommendations

1. Introduction of a program of mental hygiene in the public-school system and coöperation with state and other health authorities in making mental hygiene a part of general health work.

2. State care of all the dependent insane, drug addicts, inebriates, epileptics, and feebleminded in institutions owned and controlled by the state should be established as the definite goal of the state's policy, to be arrived at by progressive stages, in perhaps the following manner:

a. Complete the two new state hospitals for the insane at once;

b. Authorize one additional state hospital at the next session;

c. Increase the capacity of existing state institutions to the limit of efficiency, by adding such special wards and buildings as they may lack, respectively, and by founding farm colonies in connection with them;

d. Raise and enforce standards of care in county and local institutions, as a prerequisite of state aid, so that within a reasonable time only the best could survive;

e. Convert these, as occasion offers, into annexes, branches, or colonies of state hospitals.

3. Convert the Committee on Lunacy, of the Board of Public Charities, into a Board or Bureau for Mental Hygiene, and give to this board full power over all institutions and agencies dealing with the feebleminded, inebriate, epileptic, and drug addicts, as it now has power over the insane.

4. Authorize, by legislation and adequate appropriations, the organization of well-equipped *out-patient, social-service, and after-care departments* in existing institutions for mental patients, and establish a state-wide system of free *mental clinics* or dispensaries.

5. Organize psychopathic wards in general hospitals, and establish psychopathic hospitals in a few large centers, to which persons suffering from mental disease or defect, or threatened with mental or nervous breakdown, can be referred for observation and treatment, and in which research and teaching shall be integral parts of the administration.

6. Enact a law, uniform for all institutions of the same class, permitting, under proper safeguards, as in the case of the insane, the commitment of mentally defective persons to institutions, for observation and treatment, and authorizing the detention of such persons, with similar safeguards, so long as is necessary for their own protection or that of the community.

7. Increase very largely the provision now made by the state for the care of mental defectives in institutions, by enlarging the Village for Feebleminded

Women at Laurelton and the Eastern State Institution at Spring City, and by creating a new institution or separate department for defective delinquents.

8. Encourage, with state aid, the establishment of special schools and classes in the public schools for backward and defective children.

9. Provide for the mental examination of persons brought before juvenile and criminal courts, and authorize the court, under proper conditions, to commit such persons, when their mental condition warrants, to suitable institutions, for observation, treatment, and training.

10. Authorize and require a systematic examination of the inmates of penal and reformatory institutions, to determine their mental condition, and provide for the transfer to institutions for defective delinquents, as soon as created, or other appropriate institutions, of those whose mental conditions warrant such action.

SOCIAL FACTS RELATIVE TO PATIENTS WITH MENTAL DISEASES

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THE purpose of this study is to show the social significance of certain facts relative to patients admitted to state hospitals for mental diseases. It is based upon statistics compiled in accordance with the uniform system adopted by the American Medico-Psychological Association and promulgated by the National Committee for Mental Hygiene. It presents data concerning nativity, citizenship, marital condition, environment, economic condition, age distribution, and alcoholic habits of patients who entered hospitals for mental diseases for the first time during the fiscal year 1919. In the April number of MENTAL HYGIENE[1] these same admissions are studied from the point of view of their types of mental disease.

The 46 state hospitals represented in this study are located as follows: Arizona 1, Colorado 1, Iowa 4, Maine 2, Massachusetts 12, Nebraska 3, New Hampshire 1, New York 15, Rhode Island 1, South Carolina 1, South Dakota 1, and Virginia 4. On account of the wide geographical distribution and the large number of patients included, the data here presented may be considered as typical for the country as a whole, though they represent only about one third of the new admissions to all our hospitals.

The logical approach to the study of patients in institutions for mental disease is through the first admissions. It is highly important to distinguish them from readmissions. Under the heading "first admissions" are included patients admitted for the first time to any hospital for the treatment of mental diseases, except institutions for temporary care only. This study, as indicated above, is concerned primarily with first admissions.

[1] *Mental Diseases in Twelve States*, 1919. By Horatio M. Pollock and Edith M. Furbush. MENTAL HYGIENE, Vol. V, pp. 353-389, April, 1921.

Extent of Problem in the United States

(See tables 1 and 2, pages 600 and 601.)

The operations of the hospitals included in this review are shown in the following outline:

On books at beginning of the year		79,039
First admissions	16,176	
Readmissions	4,476	
Transfers	1,660	
Total received during the year		22,312
Discharged as recovered	3,325	
As improved	4,025	
As unimproved	2,041	
As without psychosis	886	
Transferred to other institutions for mental diseases	1,745	
Otherwise discharged	60	
Died	9,309	
Total discharged, transferred, and died during the year		21,391
On books at end of the year		79,960

At the end of the year 1919, there were approximately 250,000 patients with mental diseases on the books of hospitals for their treatment in this country. Assuming that the group included in this study is representative, it may be concluded that during the year 1919 there were approximately 50,000 new admissions with mental disease to the hospitals in this country and 14,000 readmissions. On the same basis there were over 32,000 discharged (not including transfers and deaths), of whom 10,400 had recovered at the time of their discharge, 12,600 were improved, 6,400 were unimproved, 2,800 were found not to have been insane, and approximately 30,000 died during the year in all the hospitals for mental diseases in this country. On account of the influenza epidemic during that year, the death rate was undoubtedly higher, and the recovery and improvement rates correspondingly lower, than under normal conditions.

Table 2 gives the sex distribution of the new admissions, and the rates per 100,000 of general population. Of the 16,176 first admissions, 8,702, or 53.8 per cent, were males, and 7,474, or 46.2 per cent, were females. In all states except New Hampshire the number of males exceeded the females. In the group studied, there were 116 males to each 100 females. The number of males to each 100 females among the first admissions and in the general population for each state is shown in the following table:

State	Among first admissions	In general population
Arizona	342	122
Colorado	151	110
Iowa	132	105
Maine	125	103
Massachusetts	113	96
Nebraska	129	108
New Hampshire	97	101
New York	111	100
Rhode Island	113	97
South Carolina	105	99
South Dakota	148	113
Virginia	117	102

The greatest disparity in sexes is found in Arizona, with over three times as many male first admissions as female. Colorado and South Dakota come next, with three males for every two females among their first admissions.

In the various states, marked differences are found in the rates of the first admissions per 100,000 of general population. Massachusetts is found to have the highest rate of first admissions per 100,000 of general population. This is due largely to the free access to the hospitals in this state on account of its laws for voluntary admission, temporary care, and observation. Wide variations are also found in the rates for the two sexes in the several states.

Native and Foreign Born

(See table 3, page 602.)

Table 3 shows the nativity of the 15,384 first admissions to the state hospitals of eleven states. The native born numbered 9,410, or 61.2 per cent, of the total, the foreign born 5,833, or 37.9 per cent, while the nativity of 139 was unascertained, and 2 were born at sea.

State	Native born		Foreign born	
	Number	Per cent	Number	Per cent
Arizona	112	50.7	103	46.6
Colorado	317	69.4	125	27.4
Iowa	705	79.6	152	17.2
Maine	344	73.8	118	25.3
Massachusetts	2,093	55.9	1,635	43.6
Nebraska	344	67.3	146	28.6
New Hampshire	197	67.5	81	27.7
New York	3,667	52.9	3,246	46.8
Rhode Island	191	58.2	135	41.2
South Dakota	170	71.4	56	23.5
Virginia	1,270	96.9	36	2.7
Total	9,410	61.2	5,833	37.9

The large number of foreign-born patients emphasizes the need of more careful examination of immigrants at the ports of entry. New York and Massachusetts together received 4,881, or 83.7 per cent, of the foreign born in these twelve states. The high percentage of foreign born among the first admissions in Arizona is due to the large number born in Mexico, which constitute 29.4 per cent of the total first admissions for that state. Ireland contributed the greatest number to the foreign born in Massachusetts, closely followed by Canada. Germany furnished the largest number of foreign born in Nebraska. Canada was the birthplace of the largest number of foreign-born first admissions in Maine and New Hampshire. Italy furnished 511 of the foreign born for New York State, followed by Russia with 505, Ireland with 494, Germany with 400, and Austria with 306. Ireland, Italy, and Canada contributed practically all of the foreign born for Rhode Island. Of South Dakota's 56 foreign born, 13

were from Germany, 11 from Norway, and 9 from Sweden. There were the smallest number of foreign born in Virginia —a total of only 36, of whom 8 were born in England.

The following summary shows the number and percentage of first admissions for those countries in which more than 100 of the foreign-born first admissions were born.

Country	Number of first admissions	Per cent of total first admissions
Ireland	953	6.2
Russia	753	4.9
Italy	733	4.8
Canada	608	4.0
Germany	539	3.5
Austria	402	2.6
England	332	2.2
Poland	195	1.3
Sweden	193	1.3
Hungary	132	0.9
Greece	110	0.7

The following table shows the rates per 100,000 of the native-born and foreign-born population of the first admissions in eleven states:

State	Rate per 100,000 of General Population of Same Nativity	
	Native-born first admissions	Foreign-born first admissions
Arizona	45.5	137.4
Colorado	39.3	106.0
Iowa	32.7	66.0
Maine	52.3	109.7
Massachusetts	76.7	152.2
Nebraska	30.3	95.9
New Hampshire	56.3	88.3
New York	49.0	116.8
Rhode Island	45.0	77.7
South Dakota	31.1	66.5
Virginia	56.3	118.5
Total	50.1	118.7

Citizenship

(See table 4, page 604.)

Table 4 presents the citizenship of the new admissions to the state hospitals of ten states for the year 1919. Of the 15,163 patients included in this table, 9,278, or 61.2 per cent, were citizens by birth. The most marked feature of the table is the large number of aliens—3,135, or 20.7 per cent of the total first admissions and 21.7 per cent of those whose citizenship was ascertained. If we add to this figure the 2,007 citizens by naturalization, the total constitutes 33.9 per cent of the first admissions and 35.7 per cent of those patients whose citizenship was ascertained. Most of these aliens—92 per cent—are found to have entered New York and Massachusetts hospitals. The following summary shows the distribution of aliens:

State	Number	Per cent of total first admissions
Colorado	1	0.2
Iowa	52	5.9
Maine	46	9.9
Massachusetts	1,046	27.9
Nebraska	20	3.9
New Hampshire	32	11.0
New York	1,853	26.7
Rhode Island	76	23.2
South Dakota	2	0.8
Virginia	7	0.5
Total	3,135	20.7

It has long been contended by the states of New York and Massachusetts that the Federal Government should assume the care of the alien insane. These states claim that under existing conditions the burden of the care of the alien insane falls upon them in disproportionate measure. This claim is borne out by the data presented in the above summary.

It has been found in New York State that the aliens among the first admissions have the same relation numerically to the first admissions as the aliens under treatment bear to the total patient population. Assuming that this is true for the

other states, there are at present at least 16,000 aliens with mental diseases under treatment in these states alone. The average cost of maintenance per patient in a state hospital is $250. On this basis, the annual cost of maintaining alien patients with mental diseases in these states alone is over $4,000,000.

The significance of the problem of the alien insane in New York State was brought out in a study prepared by Dr. Spencer L. Dawes, Special Commissioner for the Alien Insane, entitled *Report on the Alien Insane in the Civil Hospitals of New York State.* It strongly urges the exclusion, so far as possible, of both mentally diseased and mentally defective persons at the ports of entry, and the deportation of those who may have been admitted and have not become citizens. Although this report was published in 1914, it contains information that is not available elsewhere.

Marital Condition

(See table 5, page 605.)

Table 5 shows the marital condition of the first admissions to the state hospitals in twelve states. Of those patients whose marital condition was ascertained, 41.0 per cent were single, 42.6 per cent married, 13.5 per cent widowed, 2.9 per cent separated or divorced. The following table shows the corresponding percentages by sexes for the different states:

Per Cent Distribution of Marital Condition of First Admissions in Twelve States

State	Single		Married		Widowed		Separated or Divorced	
	Males	Females	Males	Females	Males	Females	Males	Females
Arizona	72.5	28.9	18.3	62.2	7.8	6.7	1.3	2.2
Colorado	52.2	24.8	34.0	55.9	8.7	14.3	5.1	5.0
Iowa	43.5	26.4	42.9	53.4	11.5	14.7	2.0	5.5
Maine	49.4	30.4	34.5	41.1	11.0	21.3	5.1	7.2
Massachusetts	47.9	39.9	40.0	40.9	9.7	17.7	2.3	1.5
Nebraska	44.0	32.1	38.4	53.4	12.3	11.3	5.3	3.2
New Hampshire	43.6	33.8	41.4	42.3	11.3	16.9	3.8	7.0
New York	48.0	32.0	40.2	45.1	8.6	19.6	3.2	3.3
Rhode Island	49.1	29.2	36.8	42.2	10.5	24.0	3.5	4.5
South Carolina	39.7	27.2	47.3	53.2	11.3	16.7	1.8	2.8
South Dakota	56.3	19.8	32.4	66.7	9.2	12.5	2.1	1.0
Virginia	49.1	31.3	40.8	49.6	8.6	17.8	1.4	1.3
Total	48.0	32.9	39.7	46.0	9.4	18.2	2.9	3.0

To a casual observer of the above summary, the high percentage of single men and of married women would seem to indicate that, from a mental-hygiene point of view, marriage is beneficial to men, but detrimental to women. The fact that 48 per cent of the males were single and 46 per cent of the females married is due partly to the large number of men who enter hospitals in early life with dementia praecox, and in part to the fact that women as a rule marry at an earlier age than do men.

Environment

(See table 6, page 606.)

The terms used in this table are the same as in the classification of the Federal Census Bureau. "Urban" applies to places having a population of 2,500 or more, and "rural" to all others.

Of the ascertained cases, 8,439, or 71.8 per cent, were from urban environment, and 3,314, or 28.2 per cent, from rural. Based upon the general population of the same environment, 69.9 per 100,000 came from urban districts and 37.9 per 100,000 from rural.

Per Cent Distribution of Environment of First Admissions in Nine States

State	Urban		Rural		Unascertained	
	Males	Females	Males	Females	Males	Females
Colorado	47.2	55.4	47.2	37.1	5.5	7.5
Iowa	57.1	59.9	37.3	38.5	5.6	1.6
Maine	51.4	51.2	48.6	48.8	....	....
Nebraska	42.4	48.4	44.4	45.7	13.2	5.8
New York	87.0	86.9	12.5	12.4	0.5	0.8
Rhode Island	96.6	96.1	3.4	3.9	....	....
South Carolina	25.3	24.7	72.0	72.0	2.7	3.3
South Dakota	39.4	74.0	60.6	26.0	....	....
Virginia	42.3	42.3	57.4	57.7	0.3	....
Total	69.8	71.8	28.5	26.9	1.7	1.3

The rates of first admissions per 100,000 of general population of the same environment are as follows:

	Males	Females	Total
Urban.....	74.3	65.6	69.9
Rural.....	40.2	35.5	37.9

These data would not support the theory frequently advanced that insanity is more prevalent in rural communities than in cities. Comparing the environment of the two sexes, it is seen that in rural districts the rate of first admissions among males is higher than that among females.

That there has been a decided movement of the population toward cities is shown by the result of the last two federal censuses. In 1910, 45.8 per cent of the general population of the country was urban, and 54.2 per cent rural. The corresponding percentages for 1920 were 51.4 per cent and 48.6 per cent. In other words, the urban population has increased 28.6 per cent, while the rural has increased only 3.1 per cent. The trend of the population from the country toward the city is further emphasized by the fact that the 1920 federal census showed that the portion of the population living in purely country districts decreased by 227,335, or six-tenths of one per cent. The movement toward cities tends to increase admissions to hospitals for mental diseases. Many persons who can get along without much difficulty in a rural environment break down under the stress and strain of life in a large city. Certain types of mental disease are found to be much more frequent in cities than in rural districts—for example, general paralysis and alcoholic psychoses.

Economic Condition

(See table 7, page 607.)

The headings in this table are used as in the United States census classification and are thus defined: "Dependent," lacking in the necessities of life or receiving aid from public funds or persons outside the immediate family; "marginal," living on daily earnings, but accumulating little or nothing, being on the margin between self-support and dependency; "comfortable," having accumulated resources sufficient to maintain self and family for at least four months.

Data with reference to the economic condition of first admissions for the year 1919 were received from nine states, including 13,853 patients. Of this number, 1,857, or 13.4 per cent, were dependent; 9,178, or 66.3 per cent, were marginal; and 2,358, or 17.0 per cent, were comfortable, while the economic condition of 460, or 3.3 per cent, was unascertained. The following summary presents corresponding percentages by sexes, with the unascertained cases excluded:

	Males	Females	Total
Dependent	13.2	14.6	13.9
Marginal	70.2	66.7	68.5
Comfortable	16.6	18.7	17.6
Total	100.0	100.0	100.0

The wide variations in the several states may be due to a misinterpretation of the terms employed. The fact that 1918 and 1919 were unusual years from an economic viewpoint may account in part for the relatively large number of persons classified as "comfortable." Conditions of unusual prosperity prevailed during the period included in this review, especially in rural districts.

It is regrettable that data are not available concerning the economic condition of the general population, so that comparisons might be made between these first admissions and the general population in this respect.

Age Distribution

(See table 8, page 608.)

In Table 8 are shown for the twelve states the age distribution of the first admissions for the year studied. The greatest numbers are admitted from twenty-five to forty years of age, with a gradual decline thereafter.

Percentage Distribution of Ages of First Admissions to State Hospitals in Twelve States, 1919

Age groups	Males	Females	Total
Under 15 years	0.8	0.8	0.8
15–19 years	6.3	5.5	6.0
20–24 years	9.4	9.9	9.6

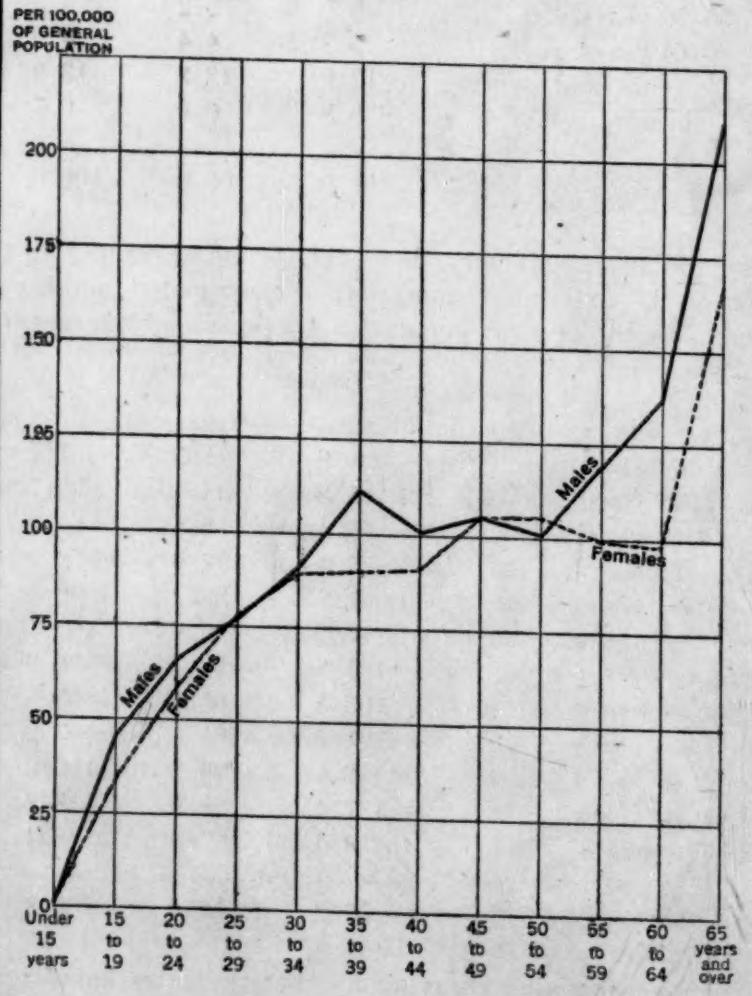
Age groups	Males	Females	Total
25–29 years	10.4	11.8	11.0
30–34 years	10.8	11.5	11.1
35–39 years	12.2	10.9	11.6
40–44 years	9.4	9.2	9.3
45–49 years	8.2	8.9	8.6
50–54 years	6.9	7.6	7.2
55–59 years	5.7	5.2	5.5
60–64 years	5.3	4.4	4.9
65 years and over	13.9	13.8	13.9
Unascertained	0.8	0.6	0.7
Total	100.0	100.0	100.0

The following summary shows the results of comparing the ages of the first admissions with the estimated number of persons in the general population by sexes and age groups:

Age groups	Admissions per 100,000 of General Population		
	Males	Females	Total
Under 15 years	1.8	1.5	1.7
15–19 years	45.8	33.7	39.7
20–24 years	65.4	58.5	61.9
25–29 years	77.4	78.6	78.0
30–34 years	91.9	89.2	90.6
35–39 years	112.2	90.6	101.7
40–44 years	101.8	91.7	96.9
45–49 years	105.5	105.6	105.5
50–54 years	101.4	105.1	103.2
55–59 years	119.5	99.7	110.0
60–64 years	137.4	98.9	118.3
65 years and over	210.4	167.8	188.4
Total	67.8	59.8	63.8

The accompanying chart shows that the rates based upon the general population of the several age groups increase with advancing years. In the age groups under fifty years, the highest rate for males is from thirty-five to thirty-nine years, and for females from forty-five to forty-nine.

RATE OF MALE AND OF FEMALE FIRST ADMISSIONS TO STATE HOSPITALS IN TWELVE STATES PER 100,000 OF GENERAL POPULATION OF THE SAME SEX AND AGE



Use of Alcohol

(See table 9, page 611.)

Table 9 presents a summary of the use of alcohol by first admissions to state hospitals in the nine states for which these data were available. Of the 14,154 patients included in the table, 6,533, or 46.2 per cent, were abstinent; 4,244, or 30.0 per cent, were temperate; 2,145, or 15.2 per cent, were intemperate; and the alcoholic habits of 1,232 were unascertained. The following summary gives the corresponding percentages by sexes, excluding the unascertained cases.

	Males	Females	Total
Abstinent.....	31.5	72.3	50.6
Temperate.....	42.2	22.1	32.8
Intemperate.....	26.3	5.6	16.6
Total.....	100.0	100.0	100.0

Over half of those first admissions whose habits with respect to alcohol were ascertained were found to be abstinent, and only one in six was intemperate—one in eighteen among the women and one in four among the men. These figures are in distinct contradiction to the assumption sometimes made that alcohol is the principal cause of mental disease.

Dr. H. M. Pollock, Statistician of the New York State Hospital Commission, recently made a study[1] of the use of alcohol and drugs among first admissions to the New York State hospitals from 1909 to 1920, inclusive. This study shows a decline in the incidence of mental disease, as well as in the number of new admissions with a history of intemperate use of alcohol, and strikes a very hopeful note for the future.

The reduction in the use of alcohol, the gradual elimination of venereal diseases, and the dissemination of more complete knowledge of the principles of mental hygiene tend to lower the rates of mental disease. On the other hand, the crowding of the population into cities, the increasing economic stress, and the reduction of the birth rate among the more stable elements of the population are conditions unfavorable to mental health.

[1] *Decline of Alcohol and Drugs as Causes of Mental Disease.* By H. M. Pollock. Mental Hygiene, Vol. 5, pp. 123-129, January, 1921.

Table 1—Movement of patients with mental diseases in state hospitals in twelve states, for the fiscal year ending in 1919

State	On books at beginning of year	Admitted during Year				Discharged from Books during Year								On books at end of year
		First admissions	Readmissions	Transfers	Total	Recovered	Improved	Unimproved	Without psychosis	Transferred	Otherwise discharged	Died	Total	
Arizona	542	221	17	.....	238	38	97	15	1	.....	.....	103	254	526
Colorado	1,741	437	20	.....	457	18	17	2	3	.....	.....	232	272	1,926
Iowa	5,425	886	189	20	1,095	252	51	29	3	119	44	502	1,000	5,520
Maine	1,918	466	131	17	614	77	81	41	45	16	.....	246	506	2,026
Massachusetts	16,495	3,746	1,490	399	5,635	449	1,059	1,204	542	440	.....	1,865	5,559	16,571
Nebraska	2,661	511	73	2	586	24	118	19	3	3	.....	252	419	2,828
New Hampshire	1,358	292	81	.....	373	29	73	29	29	.....	.....	199	359	1,372
New York	38,772	6,929	1,918	1,210	10,057	1,600	1,894	503	52	1,159	.....	4,592	9,800	39,029
Rhode Island	1,700	328	77	.....	405	81	88	48	6	.....	.....	194	417	1,688
South Carolina	2,188	812	207	.....	1,019	215	219	63	92	.....	.....	278	867	2,340
South Dakota	1,077	238	9	.....	247	47	23	17	4	.....	16	92	199	1,125
Virginia	5,162	1,310	264	12	1,586	495	305	71	106	8	.....	754	1,739	5,009
Total	79,039	16,176	4,476	1,660	22,312	3,325	4,025	2,041	886	1,745	60	9,309	21,391	79,960

Table 2—First admissions to state hospitals for mental diseases in twelve states, compared with the general population for the year 1919

State	Number			Rate per 100,000 of General Population		
	Males	Females	Total	Males	Females	Total
Arizona	171	50	221	96.6	34.7	68.8
Colorado	263	174	437	54.1	39.6	47.2
Iowa	504	382	886	41.3	32.8	37.1
Maine	259	207	466	66.8	54.8	60.9
Massachusetts	1,985	1,761	3,746	106.3	90.9	98.5
Nebraska	288	223	511	43.1	36.1	39.7
New Hampshire	144	148	292	65.0	67.2	66.1
New York	3,650	3,279	6,929	71.2	63.9	67.5
Rhode Island	174	154	328	59.0	50.8	54.8
South Carolina	415	397	812	50.0	47.4	48.7
South Dakota	142	96	238	42.4	32.4	37.7
Virginia	707	603	1,310	61.2	53.4	57.3
Total	8,702	7,474	16,176	68.1	59.3	63.8

Table 3—Nativity distribution of first admissions to state hospitals for mental diseases in eleven states, 1919

Country of Birth	Total		Arizona		Colorado*		Iowa		Maine		Massachusetts	
	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent
United States	9,410	61.2	112	50.7	317	69.4	705	79.6	344	73.8	2,093	55.9
Austria	402	2.6	4	1.8	16	3.5	8	0.9	.....	.....	48	1.3
Belgium	13	0.1	.....	.....	.....	.....	1	0.1	.....	.....	3	0.1
Bohemia	58	0.4	.....	.....	.....	.....	10	1.1	.....	.....	2	0.1
Canada	608	4.0	2	0.9	9	2.0	9	1.0	67	14.4	336	9.0
China	11	0.1	.....	.....	.....	.....	.....	.....	.....	.....	5	0.1
Denmark	50	0.3	.....	.....	5	1.1	12	1.4	.....	.....	2	0.1
England	332	2.2	2	0.9	11	2.4	7	0.8	4	0.9	123	3.3
Finland	56	0.4	1	0.5	1	0.2	.....	.....	2	0.4	22	0.6
France	46	0.3	.....	.....	.....	.....	3	0.3	.....	.....	11	0.3
Germany	539	3.5	5	2.3	7	1.5	32	3.6	3	0.6	42	1.1
Greece	110	0.7	4	1.8	.....	.....	5	0.6	1	0.2	38	1.0
Holland	28	0.2	.....	.....	.....	.....	11	1.2	.....	.....	2	0.1
Hungary	132	0.9	1	0.5	1	0.2	1	0.1	.....	.....	3	0.1
Ireland	953	6.2	3	1.4	9	2.0	8	0.9	7	1.5	385	10.3
Italy	733	4.8	3	1.4	16	3.5	4	0.5	2	0.4	169	4.5
Mexico	80	0.5	65	29.4	7	1.5	2	0.2	.....	.....	.....	.....
Norway	69	0.4	.....	.....	3	0.7	8	0.9	2	0.4	9	0.2
Poland	195	1.3	1	0.5	.....	.....	1	0.1	7	1.5	69	1.8
Portugal	52	0.3	2	0.9	.....	.....	.....	.....	.....	.....	39	1.0
Roumania	39	0.3	.....	.....	.....	.....	.....	.....	1	0.2	1	0.0
Russia	753	4.9	2	0.9	19	4.2	8	0.9	12	2.6	182	4.9
Scotland	68	0.4	1	0.5	2	0.4	.....	.....	.....	.....	21	0.6
Spain	29	0.2	1	0.5	.....	.....	.....	.....	.....	.....	4	0.1
Sweden	193	1.3	3	1.4	15	3.3	17	1.9	2	0.4	60	1.6
Switzerland	30	0.2	.....	.....	2	0.4	4	0.5	.....	.....	1	0.0
Turkey	74	0.5	1	0.5	.....	.....	.....	.....	.....	.....	26	0.7
West Indies	76	0.5	.....	.....	.....	.....	.....	.....	.....	.....	14	0.4
Other countries	†106	0.7	2	0.9	2	0.4	1	0.1	8	1.7	19	0.5
Unascertained	139	0.9	6	2.7	15	3.3	29	3.3	4	0.9	17	0.5
Total	15,384	100.0	221	100.0	457	100.0	886	100.0	466	100.0	3,746	100.0

* Includes 20 readmissions. † Includes 2 patients born at sea.

* Includes 20 readmissions.

† Includes 2 patients born at sea.

Table 3—Nativity distribution of first admissions to state hospitals for mental diseases in eleven states, 1919—Concluded

Country of Birth	Nebraska		New Hampshire		New York		Rhode Island		South Dakota		Virginia	
	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent
United States	344	67.3	197	67.5	3,667	52.9	191	58.2	170	71.4	1,270	96.9
Austria	9	1.8	1	0.3	306	4.4	5	1.5	1	0.4	4	0.3
Belgium	2	0.4	1	0.3	6	0.1	.....	.....	.....	.....	.....	.....
Bohemia	17	3.3	.....	.....	25	0.4	.....	.....	3	1.3	1	0.1
Canada	2	0.4	45	15.4	113	1.6	22	6.7	3	1.3	.....	.....
China	.....	.....	1	0.3	5	0.1	.....	.....	.....	.....	.....	.....
Denmark	6	1.2	.....	.....	20	0.3	.....	.....	3	1.3	2	0.2
England	7	1.4	4	1.4	147	2.1	18	5.5	1	0.4	8	0.6
Finland	1	0.2	3	1.0	26	0.4	.....	.....	.....	.....	.....	.....
France	1	0.2	1	0.3	26	0.4	3	0.9	1	0.4	.....	.....
Germany	27	5.3	3	1.0	400	5.8	4	1.2	13	5.5	3	0.2
Greece	3	0.6	3	1.0	53	0.8	1	0.3	.....	.....	2	0.2
Holland	3	0.6	.....	.....	12	0.2	.....	.....	.....	.....	.....	.....
Hungary	1	0.2	.....	.....	121	1.7	.....	.....	1	0.4	3	0.2
Ireland	6	1.2	8	2.7	494	7.1	28	8.5	4	1.7	1	0.1
Italy	3	0.6	.....	.....	511	7.4	24	7.3	.....	.....	1	0.1
Mexico	.....	.....	.....	.....	6	0.1	.....	.....	.....	.....	.....	.....
Norway	6	1.2	.....	.....	30	0.4	.....	.....	11	4.6	.....	.....
Poland	4	0.8	2	0.7	107	1.5	1	0.3	.....	.....	3	0.2
Portugal	.....	.....	.....	.....	6	0.1	5	1.5	.....	.....	.....	.....
Roumania	1	0.2	.....	.....	34	0.5	2	0.6	.....	.....	.....	.....
Russia	7	1.4	3	1.0	505	7.3	8	2.4	4	1.7	3	0.2
Scotland	.....	.....	2	0.7	37	0.5	4	1.2	1	0.4	.....	.....
Spain	.....	.....	.....	.....	24	0.3	.....	.....	.....	.....	.....	.....
Sweden	16	3.1	4	1.4	64	0.9	2	0.6	9	3.8	1	0.1
Switzerland	3	0.6	.....	.....	20	0.3	.....	.....	.....	.....	.....	.....
Turkey	.....	.....	.....	.....	39	0.6	8	2.4	.....	.....	.....	.....
West Indies	.....	.....	.....	.....	60	0.9	.....	.....	.....	.....	2	0.2
Other countries	21	4.1	.....	.....	50	0.7	.....	.....	1	0.4	2	0.2
Unascertained	21	4.1	14	4.8	15	0.2	2	0.6	12	5.0	4	0.3
Total	511	100.0	292	100.0	6,929	100.0	328	100.0	238	100.0	1,310	100.0

Table 4—Citizenship of first admissions to state hospitals for mental diseases in ten states, 1919

State	Total			Citizens by Birth			Citizens by Naturalization			Aliens			Citizenship Unascertained		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
Colorado*	271	186	457	188	129	317	77	48	125	1	.....	1	5	9	14
Iowa	504	382	886	384	322	706	40	7	47	48	4	52	32	49	81
Maine	259	207	466	186	164	350	18	25	43	40	6	46	15	12	27
Massachusetts	1,985	1,761	3,746	1,105	985	2,090	225	186	411	555	491	1,046	100	99	199
Nebraska	288	223	511	194	151	345	9	8	17	12	8	20	73	56	129
New Hampshire	144	148	292	101	97	198	6	17	23	18	14	32	19	20	39
New York	3,650	3,279	6,929	1,887	1,747	3,634	618	638	1,256	1,082	771	1,853	63	123	186
Rhode Island	174	154	328	107	80	187	25	25	50	35	41	76	7	8	15
South Dakota	142	96	238	103	72	175	15	3	18	2	.....	2	22	21	43
Virginia	707	603	1,310	683	593	1,276	11	6	17	6	1	7	7	3	10
Total	8,124	7,039	15,163	4,938	4,340	9,278	1,044	963	2,007	1,799	1,336	3,135	343	400	743

* Includes 20 readmissions.

Table 5—Marital condition of first admissions to state hospitals for mental diseases in twelve states, 1919

Marital Condition	Total			Arizona			Colorado*			Iowa			Maine			Massachusetts		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
Single	4,099	2,416	6,515	111	13	124	132	40	172	215	101	316	126	63	189	940	698	1,638
Married	3,389	3,378	6,767	28	28	56	86	90	176	212	204	416	88	85	173	785	715	1,500
Widowed	805	1,335	2,140	12	3	15	22	23	45	57	56	113	28	44	72	191	310	501
Separated	133	129	262	.....	1	1	7	5	12	3	8	11	4	6	10	16	7	23
Divorced	111	92	203	2	.....	2	6	3	9	7	13	20	9	9	18	29	19	48
Unascertained	173	136	309	18	5	23	18	25	43	10	.....	10	4	.....	4	24	12	36
Total	8,710	7,486	16,196	171	50	221	271	186	457	504	382	886	259	207	466	1,985	1,761	3,746

Marital Condition	Nebraska			New Hampshire			New York			Rhode Island			South Carolina			South Dakota			Virginia		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
Single	125	71	196	58	48	106	1,726	1,025	2,751	84	45	129	159	106	265	80	19	99	343	187	530
Married	109	118	227	55	60	115	1,443	1,446	2,889	63	65	128	189	207	396	46	64	110	285	296	581
Widowed	35	25	60	15	24	39	309	630	939	18	37	55	45	65	110	13	12	25	60	106	166
Separated	3	3	6	3	5	8	86	86	172	2	....	2	7	8	15	....	....	....	2	....	2
Divorced	12	4	16	2	5	7	29	20	49	4	7	11	....	3	3	3	1	4	8	8	16
Unascertained	4	2	6	11	6	17	57	72	129	3	....	3	15	8	23	....	....	....	9	6	15
Total	288	223	511	144	148	292	3,650	3,279	6,929	174	154	328	415	397	812	142	96	238	707	603	1,310

* Includes 20 readmissions.

Table 6—Environment of first admissions to state hospitals for mental diseases in nine states, compared with the general population for 1919*

State	Urban				Rural			
	Number			Rate per 100,000	Number			Rate per 100,000
	Males	Females	Total		Males	Females	Total	
Colorado	128	103	231	51.5	128	69	197	41.3
Iowa	228	229	517	60.4	188	147	335	21.9
Maine	133	106	239	80.8	126	101	227	48.3
Nebraska	122	108	230	58.1	128	102	230	25.8
New York	3,174	2,848	6,022	71.3	458	405	863	47.7
Rhode Island	168	148	316	54.2	6	6	12	77.5
South Carolina	105	98	203	70.7	299	286	585	42.4
South Dakota	56	71	127	127.8	86	25	111	20.9
Virginia	299	255	554	84.7	406	348	754	46.3
Total	4,473	3,966	8,439	69.9	1,825	1,489	3,314	37.9

* 184 patients whose environment was unascertained were excluded.

Table 7—Economic condition of first admissions to state hospitals for mental diseases in nine states, 1919

State	Total			Dependent			Marginal			Comfortable			Unascertained		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
Colorado*	271	186	457	6	.....	6	254	174	428	4	2	6	7	10	17
Iowa	504	382	886	95	53	148	194	170	364	152	133	285	63	26	89
Maine	259	207	466	49	36	85	19	6	25	182	165	347	9	.....	9
Massachusetts	1,985	1,761	3,746	207	274	481	1,403	1,257	2,660	302	229	531	73	1	74
Nebraska	288	223	511	90	101	191	145	90	235	35	21	56	18	11	29
New Hampshire	144	148	292	62	57	119	60	52	112	20	38	58	2	1	3
New York	3,650	3,279	6,929	394	357	751	2,842	2,395	5,237	290	414	704	124	113	237
Rhode Island	174	154	328	25	27	52	63	30	93	84	97	181	2	.....	2
South Dakota	142	96	238	15	9	24	9	15	24	118	72	190	.....	.....	.....
Total	7,417	6,436	13,853	943	914	1,857	4,989	4,189	9,178	1,187	1,171	2,358	298	162	460

* Includes 20 readmissions.

Table 8—Age distribution of first admissions to state hospitals for mental diseases in twelve states, 1919

Age Group	Total				Arizona				Colorado*				Iowa			
	Number			Per cent	Number			Per cent	Number			Per cent	Number			Per cent
	M.	F.	T.		M.	F.	T.		M.	F.	T.		M.	F.	T.	
Under 15 years	68	58	126	0.8	1	2	3	1.4	3	1	4	0.9	4	1	5	0.6
15 to 19 years	550	414	964	6.0	14	7	21	9.5	17	8	25	5.5	9	8	17	1.9
20 to 24 years	817	742	1,559	9.6	14	2	16	7.2	19	10	29	6.3	41	32	73	8.2
25 to 29 years	905	884	1,789	11.0	16	3	19	8.6	22	14	36	7.9	36	43	79	8.9
30 to 34 years	937	862	1,799	11.1	17	5	22	10.0	33	19	52	11.4	57	53	110	12.4
35 to 39 years	1,065	813	1,878	11.6	26	11	37	16.7	29	22	51	11.2	63	42	105	11.9
40 to 44 years	817	685	1,502	9.3	16	1	17	7.7	23	16	39	8.5	36	38	74	8.4
45 to 49 years	718	669	1,387	8.6	12	4	16	7.2	21	17	38	8.3	42	40	82	9.3
50 to 54 years	598	567	1,165	7.2	11	2	13	5.9	16	16	32	7.0	45	35	80	9.0
55 to 59 years	499	388	887	5.5	8	1	9	4.1	8	13	21	4.6	41	26	67	7.6
60 to 64 years	459	327	786	4.9	4	.....	4	1.8	29	7	36	7.9	36	18	54	6.1
65 to 69 years	420	273	693	4.3	6	.....	6	2.7	11	10	21	4.6	25	12	37	4.2
70 years and over	791	762	1,553	9.6	12	3	15	6.8	27	24	51	11.2	60	28	88	9.9
Unascertained	66	42	108	0.7	14	9	23	10.4	13	9	22	4.8	9	6	15	1.7
Total	8,710	7,486	16,196	100.0	171	50	221	100.0	271	186	457	100.0	504	382	886	100.0

* Includes 20 readmissions.

Table 8—Age distribution of first admissions to state hospitals for mental diseases in twelve states, 1919—Continued

Age Group	Maine				Massachusetts				Nebraska				New Hampshire			
	Number			Per cent	Number			Per cent	Number			Per cent	Number			Per cent
	M.	F.	T.		M.	F.	T.		M.	F.	T.		M.	F.	T.	
Under 15 years	1	1	2	0.4	30	15	45	1.2	1	.....	1	0.2	3	2	5	1.7
15 to 19 years	14	9	23	4.9	136	143	279	7.4	8	9	17	3.3	7	5	12	4.1
20 to 24 years	25	11	36	7.7	184	190	374	10.0	23	21	44	8.6	11	8	19	6.5
25 to 29 years	22	18	40	8.6	190	203	393	10.5	27	27	54	10.6	11	15	26	8.9
30 to 34 years	25	21	46	9.9	248	204	452	12.1	25	26	51	10.0	12	14	26	8.9
35 to 39 years	35	21	56	12.0	225	178	403	10.8	33	32	65	12.7	19	22	41	14.0
40 to 44 years	22	13	35	7.5	184	149	333	8.9	30	23	53	10.4	9	17	26	8.9
45 to 49 years	26	21	47	10.1	173	149	322	8.6	16	16	32	6.3	13	8	21	7.2
50 to 54 years	17	25	42	9.0	136	119	255	6.8	19	13	32	6.3	10	13	23	7.9
55 to 59 years	11	18	29	6.2	117	80	197	5.3	29	12	41	8.0	6	10	16	5.5
60 to 64 years	16	8	24	5.2	105	68	173	4.6	11	9	20	3.9	5	13	18	6.2
65 to 69 years	25	5	30	6.4	87	59	146	3.9	17	7	24	4.7	10	3	13	4.5
70 years and over	20	34	54	11.6	170	204	374	10.0	38	25	63	12.3	24	15	39	13.4
Unascertained	.....	2	2	0.4	.....	.....	.....	.....	11	3	14	2.7	4	3	7	2.4
Total	259	207	466	100.0	1,985	1,761	3,746	100.0	288	223	511	100.0	144	148	292	100.0

Table 8—Age distribution of first admissions to state hospitals for mental diseases in twelve states, 1919—Concluded

Age Group	New York				Rhode Island				South Carolina				South Dakota				Virginia			
	Number			Per cent	Number			Per cent	Number			Per cent	Number			Per cent	Number			Per cent
	M.	F.	T.		M.	F.	T.		M.	F.	T.		M.	F.	T.		M.	F.	T.	
Under 15 years	13	9	22	0.3	....	....	....	....	8	16	24	3.0	....	....	....	....	4	11	15	1.1
15 to 19 years	207	137	344	5.0	10	2	12	3.7	55	39	94	11.6	8	2	10	4.2	65	45	110	8.4
20 to 24 years	312	313	625	9.0	15	13	28	8.5	47	63	110	13.5	19	10	29	12.2	107	69	176	13.4
25 to 29 years	431	419	850	12.3	22	16	38	11.6	42	46	88	10.8	13	6	19	8.0	73	74	147	11.2
30 to 34 years	399	378	777	11.2	16	18	34	10.4	30	42	72	8.9	10	15	25	10.5	65	67	132	10.1
35 to 39 years	491	336	827	11.9	20	16	36	11.0	36	45	81	10.0	18	15	33	13.9	70	73	143	10.9
40 to 44 years	375	334	709	10.2	20	11	31	9.5	28	28	56	6.9	11	12	23	9.7	63	43	106	8.1
45 to 49 years	309	316	625	9.0	17	13	30	9.1	33	32	65	8.0	12	5	17	7.1	44	48	92	7.0
50 to 54 years	258	262	520	7.5	8	14	22	6.7	22	21	43	5.3	13	6	19	8.0	43	41	84	6.4
55 to 59 years	213	178	391	5.6	11	10	21	6.4	18	10	28	3.4	7	7	14	5.9	30	23	53	4.0
60 to 64 years	173	154	327	4.7	6	4	10	3.0	27	11	38	4.7	10	2	12	5.0	37	33	70	5.3
65 to 69 years	168	123	291	4.2	8	8	16	4.9	21	17	38	4.7	11	4	15	6.3	31	25	56	4.3
70 years and over	292	314	606	8.7	21	29	50	15.2	46	23	69	8.5	9	12	21	8.8	72	51	123	9.4
Unascertained	9	6	15	0.2	....	....	....	....	2	4	6	0.7	1	....	1	0.4	3	....	3	0.2
Total	3,650	3,279	6,929	100.0	174	154	328	100.0	415	397	812	100.0	142	96	238	100.0	707	603	1,310	100.0

Table 9—Use of alcohol by first admissions to state hospitals for mental diseases in nine states, 1919

State	Total	Abstinent	Temperate	Intemperate	Unascertained
Colorado*	457	6	359	44	48
Iowa	886	505	132	108	141
Maine	466	169	174	93	30
Massachusetts	3,746	2,003	847	687	209
New Hampshire	292	157	45	38	52
New York	6,929	2,891	2,364	1,034	640
Rhode Island	328	138	115	51	24
South Carolina	812	464	199	63	86
South Dakota	238	200	9	27	2
Total	14,154	6,533	4,244	2,145	1,232

* Includes 20 readmissions.

ELIZABETH MILBANK ANDERSON

IN the death of Elizabeth Milbank Anderson the National Committee for Mental Hygiene has lost a member whose generous material support was accompanied by real companionship and sympathetic understanding of the complex human problems with which this organization has to deal. She saw that the protection of mental health rarely had a place in the broad movements for hygiene and sanitation that received her aid, and that the resources of science and humanity which she helped so often to bring to the assistance of the sick rarely, if ever, reached those who suffer from mental diseases. It touched her heart to see the welfare of so large a class of sick people uninfluenced by the generosity of those who give to hospitals, clinics, and nursing service, and her keen mind saw how illogical it was that a whole field of health should lie outside the rapidly spreading public-health effort of the times simply through the survival of prejudices that arose in the darkness of the past.

In 1915, when Mrs. Anderson came to the aid of the National Committee for Mental Hygiene at a critical time, there was but little assurance that this new organization would achieve any considerable measure of success in the tasks that it had hopefully set for itself. It is significant of her willingness to help the weak as well as the strong that she was not deterred by the chance of failure. That success quickly followed, and a new popular point of view regarding mental disease gained ground in time to influence profoundly the treatment of mentally disabled American soldiers during the war, was a source of the greatest pleasure to the wise, kind woman who had taken a chance when caution might have dictated another course.

Elsewhere are recorded the contributions of interest, personal encouragement, sound advice, and generous financial assistance that Mrs. Anderson gave during her life and insured for the years to come to other organizations for the promotion of human welfare and the relief of human suffering. The diversity of their fields of work testifies to the breadth of her humanitarian interests. It is desired to record here only the sorrow of the officers and members of this association over the termination of her useful life, the inspiration that her memory furnishes for the future, and the great debt which those upon whom the shadow of mental illness rests or over whom it hovers owe to one whose benevolence passed formal bounds in zeal to find new opportunities for helpfulness.

ABSTRACTS

EXPERT TESTIMONY IN CRIMINAL PROCEDURE INVOLVING THE QUESTION OF THE MENTAL STATE OF THE DEFENDANT. By William A. White, M.D. *Journal of Criminal Law and Criminology*, 11: 499-511, February, 1921.

The disrepute into which expert medical testimony in criminal cases has fallen is, in Dr. White's opinion, to be traced to one main cause—the fact that the present method of criminal procedure is not what it pretends to be. The expert witness is hired and paid by one side in an essentially partisan contest, for that is what the trial of a criminal case before a jury undeniably is at the present time; he represents that side and all his interests are on that side, yet he is asked to preserve a strictly nonpartisan attitude and to answer all questions fairly and impartially. This demand is psychologically an impossible one to meet. "The witness generally errs in one of two directions—either he is distinctly partisan or, because of being in fear that he will be partisan, he leans over so far backward that he unnecessarily injures the cause which he represents. The former of the two errors is naturally the more frequent, but it is not an error born of dishonesty, for, far from having any intent to deceive, the witness honestly tries his best, in the great majority of cases, to present his views fairly, but it is an error born of a natural weakness of human nature as it fails before an impossible task." This partisanship—"which does, as a matter of fact, exist, no matter how strongly it may be denied"—is, Dr. White believes, at the root of the public's antagonistic attitude toward expert testimony; but it is not a thing for which the medical man should be blamed—it is the result of a wrong system, a system not of his making.

The following statute, drawn up by a committee of the American Institute of Criminal Law and Criminology, and adopted by the institute without a dissenting voice, is offered as a suggestion for the correcting of the method of procedure as it now exists:

"SECTION 1. Where the existence of mental disease or derangement on the part of any person becomes an issue in the trial of a case, the judge of the trial court may summon one or more disinterested qualified experts, not exceeding three, to testify at the trial. In case the judge shall issue the summons before the trial is begun, he shall notify counsel for both parties of the witnesses so summoned. Upon the trial of the case, the witnesses summoned by the court may be cross-examined by counsel for both parties in the case. Such sum-

moning of witnesses by the court shall not preclude either party from using other expert witnesses at the trial.

"SECTION 2. In criminal cases, no testimony regarding the mental condition of the accused shall be received from witnesses summoned by the accused until the expert witnesses summoned by the prosecution have been given an opportunity to examine the accused.

"SECTION 3. Whenever in the trial of a criminal case the existence of mental disease on the part of the accused, either at the time of the trial or at the time of the commission of the alleged wrongful act, becomes an issue in the case, the judge of the court before which the accused is to be tried or is being tried shall commit the accused to the state hospital for the insane, to be detained there for purposes of observation until further order of court. The court shall direct the superintendent of the hospital to permit all the expert witnesses summoned in the case to have free access to the accused for purposes of observation. The court may also direct the chief physician of the hospital to prepare a report regarding the mental condition of the accused. This report may be introduced in evidence at the trial under oath of said chief physician, who may be cross-examined regarding the report by counsel for both sides.

"SECTION 4. Each expert witness may prepare a written report upon the mental condition of the person in question, and such report may be read by the witness at the trial. If the witness presenting the report was called by one of the opposing parties, he may be cross-examined regarding his report by counsel for the other party. If the witness was summoned by the court, he may be cross-examined regarding his report by counsel for both parties.

"SECTION 5. Where expert witnesses have examined the person whose mental condition is an element in the case, they may consult with or without the direction of court, and if possible prepare a joint report to be introduced at the trial."

The adoption of such a statute as this, however, would by no means solve all the difficulties connected with the question of criminal procedure and expert medical testimony. "In the first place the law as it exists on the statute books is still essentially a law of revenge;" it is concerned with the crime rather than with the criminal, with conduct as of this or that type rather than as the reaction of a particular individual to stimuli without and within. Modern science, on the other hand, is concerned with correcting rather than with punishing; it recognizes the fact that crime cannot be considered apart from the individual criminal, or dealt with intelligently except as the result of that particular individual's maladjustment to society. "If the individual be studied carefully, it can always be seen how a

given crime issues logically out of the antecedents in that individual's life. The unfolding of the individual's character in relation to the total situation in which the crime occurred makes it at once understandable. In this day and age, the revenge attitude of society against the criminal is unintelligent. The attitude that should be assumed and that science is forcing upon the courts and the legislatures is the attitude of endeavoring to deal efficiently with the problems that the individual presents, with the deep conviction that arbitrary terms of imprisonment and capital punishment are not the last words in serving this end."

From this general criticism of the existing system of legal procedure, Dr. White passes on to a discussion of three particular points in which he feels it to be out of accord with modern scientific thought. There is, first, the supposition that judge and jury are unprejudiced—"able to consider the evidence solely upon its merits and arrive at conclusions free from personal bias." To students of present-day psychology, it is evident that this is impossible, since such a thing as an unprejudiced individual does not exist. "The reason why I make this statement so definitely," Dr. White explains, "is because it is generally conceded by those engaged in the study of psychology that mental actions are necessarily conditioned by all that has gone into the composition of the fabric of the mind, whether all those elements which for the time being are operative are present in consciousness or not. In other words, an opinion is the outcome of the whole tendency of the individual as it has been built up during his lifetime, and whether he thinks it or not, he is swayed at every point by these ingrained tendencies.

"Every human being must, therefore, of necessity approach every problem with the natural bias of his own personality make-up, based as it is upon the totality of his hereditary tendencies, his upbringing, and his past experiences. . . . Prejudice in this sense is an ineradicable element of the human mind, and the best that can be done is to attempt to reduce it to a minimum. The medical expert who is aware of the true state of affairs is a safer witness than one who is blind to its possibilities, and the same may be said of a judge or in fact any one searching for the truth in the tangled network of human motives. The law should face this fact squarely and no longer refuse to see it. The procedure in attempting to get at the facts would be made simpler by so doing."

The hypothetical question, again, is a psychological absurdity. It is based upon the theory that it is the jury's function, not the expert's, to decide whether the defendant is or is not of sound mind. There does not seem to be any particular reason why the jury should

not hear the expert's opinion of the mental condition of the defendant, and as a matter of fact the hypothetical question is a mere quibble. The jury knows and every one else knows that when the expert answers the question, he is expressing his opinion of the defendant. It would, indeed, be psychologically impossible for him to consider the facts included in the hypothetical question by themselves, apart from his knowledge of the defendant.

The question of the responsibility of the defendant is another unscientific concept of law. Responsibility is regarded as a definite possession, which the criminal is supposed either to have or not to have, much as he might possess or not possess certain real estate or some other tangible asset. "Such ways of dealing with human beings show an absolute lack of understanding of the principles of conduct, and belong to the same stage of development as the spirit of revenge. To conceive that an individual is either absolutely responsible or absolutely irresponsible is to fly in the face of perfectly patent facts that are in everybody's individual experience, and is comparable only to such beliefs of the middle ages as that a person is possessed of a devil or is not possessed of a devil and is therefore a free moral agent." The question of responsibility, Dr. White believes, is determined by the jury by the process of making up their minds, from the facts presented to them, whether they think the defendant ought to be punished or not; if they think that he ought to be punished, they conclude that he was responsible and therefore guilty. Responsibility is thus something that exists in the minds of the jury rather than in the mind of the defendant.

The function of the expert should be to bring his specialized knowledge to the service of the court. He should be placed in as impersonal an attitude toward the issue as the judge and jury, and he should have the opportunity to set forth a coherent, connected account of the defendant, analyzing his character make-up, showing how he came to be the manner of man he is, and explaining the crime in relation to this setting. With such a complete picture before them, the jurors can pass intelligently upon the issue.

A Psychological Study of Motion Pictures in Relation to Venereal-Disease Campaigns. By Karl S. Lashley, Ph.D., and John B. Watson Ph.D. *Social Hygiene*, 7:181-219, April, 1921.

This paper is a condensed form[1] of the report of an investigation conducted by the Psychological Laboratory of Johns Hopkins Uni-

[1] The complete report is being published as a monograph. Any one interested may obtain further information by addressing the American Social Hygiene Association, 370 Seventh Avenue, New York City.

versity for the United States Interdepartmental Social Hygiene Board as to the effectiveness of certain motion-picture films used in venereal-disease campaigns and the value of motion pictures in sex-education work in general. The study was made by the authors under the general supervision of an advisory board consisting of Dr. Adolf Meyer, Dr. Shepherd I. Franz, and Professor Robert S. Woodworth.[2]

The aim of popular education in sex hygiene is twofold: (1) to increase popular knowledge of the facts with regard to sexual physiology and psychology and (2) to arouse an emotional attitude that will result in the actual application of the information received, since it is doubtful whether information unaccompanied by emotional factors will have any significant effect upon behavior. The problem of the authors, therefore, was to determine both the informational and the emotional effects of the pictures being shown to the public on the subject of sex hygiene and also, if possible, the transitory and permanent effects that they produce upon the behavior of those who see them.

It was decided to concentrate the investigation upon one film, and *Fit to Win*, one of the films used in army camps in the campaign against venereal disease and later revised for civilian use, was selected as the best adapted to the purposes of the investigation. It is also the one that seems to be provocative of most of the criticism directed against sex-hygiene films, emphasizing as it does both the danger of disease and the value of prophylaxis without stressing the moral aspects of the problem, using language that is frequently crude, and showing certain scenes that are open to the charge of pornography. Study of it, therefore, should reveal most of the bad effects that have been laid at the door of this and other sex films.

The following are the main points that *Fit to Win* is designed to teach: (1) that continence is in no way injurious to health, but that the continent man is physically superior to the incontinent; (2) that seminal emissions are not harmful unless occurring more frequently than twice weekly; (3) that venereal diseases are very serious and may lead to total disability unless given careful and long-continued treatment; (4) that venereal diseases are the result of infection by microörganisms; (5) that syphilis is communicable by contact or by the use of toilet articles of an infected person; (6) that the use of prophylaxis, after exposure, is advisable, but must be prompt and careful to be effective; (7) that both syphilis and gonorrhea require persistent and long-continued treatment; (8) that the government

[2] For a special phase of this study see *A Consensus of Medical Opinion Upon Questions Relating to Sex Education and Venereal-Disease Campaigns*, by John B. Watson and K. S. Lashley. MENTAL HYGIENE, Vol. IV, pp. 769-847, October 1920

maintains recreation rooms for soldiers and that various forms of wholesome recreation may serve as a substitute for the bawdy house; (9) that venereal infections constitute a serious loss to the government and a severe handicap in the prosecution of the war; (10) that doctors who advertise quick cures for venereal diseases are unreliable.

The picture makes also a number of emotional appeals: (1) the influence of a sweetheart in keeping a man continent is shown; (2) the men are urged to remain continent from patriotic motives; (3) the infected men are shown in contrast to the fit in a way to touch the pride of the men who see the picture; (4) some of the scenes appeal to parental and filial affection; and (5) others are calculated to arouse fear of infection. The possibility that the picture might produce harmful emotional reactions—such as morbid fear of infection amounting to a phobia, excessive interest or curiosity about sex matters, or sex antagonism on the part of women toward men in general—had also to be taken in consideration.

The investigation was conducted by means of questionnaires, observation of the audiences, personal interviews, and follow-up work carried on with the coöperation of social workers, physicians, and others in the various places in which the picture was shown.

The audiences varied widely in education, social tradition, and economic standards. They included a medical group; a clerical and executive group; a group made up of the members of a women's social and literary club; a mixed audience of both sexes, fully half of them boys and girls under seventeen, gathered at a free performance in a village in Pennsylvania; a group of car men; a group of sailors, most of them ordinary seamen; and a group of soldiers, mostly enlisted men. Also, four performances—one each for men and women, white and colored—were given in each of two towns of about 8,000 inhabitants on the Eastern Shore of Maryland. Altogether, during the course of the experiment, between 4,800 and 5,000 persons saw the picture; 1,230 questionnaires were obtained; nearly 100 men were personally interviewed; and verbal reports on the after effects of the picture were received from 73 voluntary field workers whose observations extended for periods up to six months after the performances. The authors feel that the data obtained may be looked upon as a fair sample of the effects that the picture might produce in any community.

From these data the authors draw the following conclusions with regard (1) to the effectiveness of such films as *Fit to Win* in venereal-disease campaigns and (2) to the value of the motion-picture method in general sex-education work:

Fit to Win is moderately successful in conveying information. The questionnaires showed that at least 50 per cent of those who were

previously ignorant or misinformed acquired from the picture some definite information on each of the ten more important topics dealt with, this raising the average level of information to 70 per cent with a fairly accurate knowledge of each topic. "Naturally the amount of information acquired varied with the space devoted to the topic and the clearness and emphasis with which it was presented. Practically all learned the ready communicability of venereal disease by contact; relatively few the distinction between syphilis and gonorrhea in this respect. And so with other topics. Only where the information given was simple, clear, and without the assumption of preëxisting knowledge did any large percentage of the audience grasp it."

As to the emotional effects of the picture and its after effects, the authors state: "There is clear evidence that only in rare cases is any sexual excitement produced and there is no danger whatever that the picture will lead to immediate incontinence. On the contrary, according to the reports of men, it has some inhibitory influence, although this is not strong enough to withstand any strong temptation. No sex antagonism is produced either in men or women. There is no evidence that any dangerous interest in sex is aroused, even in children, but our data on this point are limited to one group of boys and are scarcely adequate. With audiences limited to one sex there has been no indication of emotional shock or serious offense at even the crudest parts of the picture.

"With men the film arouses some fear of venereal infection and a resultant determination to be careful, chiefly by avoiding prostitutes. There is little indication of any other constructive emotional influence. Among mature women sympathy for the innocently infected is more frequently aroused, with a desire to guarantee better education for young men and women. In neither sex does the fear of disease seem strong enough to induce morbid reactions.

"The attitude toward the film aroused in both men and women is one of approval. Ninety-five per cent of the men and 100 per cent of the women studied believed that the picture would be beneficial and that it should be shown to the general public. More than half of the men believed that it should not be shown to women (sisters or sweethearts), but all of the women believed that it should be shown even to young girls.

"The picture is not adapted for showing to mixed audiences under any conditions where the men and women may meet immediately after the performances. In one such experiment we found that inhibitions were broken down among the younger people and that comments bordering on the indecent were passed between the boys and

girls. This seemed to have been the result of a temporary relaxation produced by the picture plus the knowledge that each had seen the picture and been somewhat embarrassed before the other. Where the picture was shown to one sex only, we could find no evidence of flippant attitude in any part of the audience.

"Only two important after effects upon behavior have been demonstrated. A few individuals are stimulated to active interest in sex-hygiene campaigns. They seek to get repeated showings of the film or to obtain pamphlets and other propaganda material. They seem to be, for the most part, individuals who are already interested in the problem and who see in the performance an opening wedge for further work. A small number of men, in the belief that they may be infected, seek medical advice. The number of these that we were able to trace amounts to about 1 per cent of the total male audience.

"No lasting effects were found. The retention tests show that the main facts were remembered very well for periods up to five months, but there is no indication that behavior is modified significantly. The picture does not reduce the exposure rate of men who see it or make them more careful in the use of prophylaxis, except possibly for a few days. Nor did ill effects seem to persist to any great extent. Interest dies out rapidly, and the picture seems to be forgotten as quickly as the average motion picture devised solely for amusement.

"The effectiveness of the picture thus seems to be limited to conveying information concerning venereal diseases. While the dramatic portions of it do no active harm, it is doubtful if they contribute in any way to its educative value or add to the interest which the facts presented have for the audience. Indirectly, they cut down the space that can be devoted to informational topics and limit the informative value of the picture. The need for more elementary and comprehensive instruction than is included in *Fit to Win* leads us to believe that the development of more complete and scientifically accurate expository films along the lines already begun in the lecture films of the American Social Hygiene Association will prove more effective and profitable than will an attempt to continue the use of the dramatic method of presentation."

This judgment as to the value of the dramatic method of presenting material applies also to work in sex education. Here, too, the treatment should be simple, expository, and kept as nearly as possible on a purely scientific plane. "The use of popular instead of scientific names is inadvisable, since the meaning of the latter is almost always acquired from the context, while the former may be taken as obscenely humorous." The authors feel, however, that motion pictures are not the best method of instruction in the field in which sex educa-

tion is most vital: "The one place where we can hope to effect permanent control of sexual conduct through education is in adolescence. Films of the type of *Fit to Win* are not adapted for use at this age, and it is doubtful if any motion picture will ever be as satisfactory here as other educational methods, since there is need for adaptation of the material to the individual requirements of the youth. The films seem particularly effective, however, in arousing in adults an appreciation of the need for education and control of sex in adolescence. The most promising sphere of usefulness for motion pictures would seem, therefore, to be in building up a public opinion that will favor the utilization of other educational methods which can be better adapted to the individual needs of children and adolescents."

ALCOHOL AND SYPHILIS AS CAUSES OF MENTAL DISEASE. By George H. Kirby, M.D. *The Journal of The American Medical Association*, 76:1062-66, April 16, 1921.

Statistics published in recent years both in Europe and in America led to the generally accepted conclusion that alcohol and syphilis were the causes of from one-fifth to one-fourth of all cases of mental disease that required hospital treatment. Among male patients, the proportion was even higher—from one-fourth to one-third. Within the last decade or so, however, there have been certain developments in social life and in medical science that may be expected to have a marked effect upon the prevalency and potency of these two outstanding causes of mental disease. These developments are the reaction against alcohol—which has found concrete expression in an ever-increasing application of local option, in the passage of state-wide restrictive laws, and finally in the adoption of the prohibition amendment to the Constitution—and the introduction of new methods of detecting and treating syphilis, notably the use of arsphenamin in treatment, combined with the spread of information with regard to that disease among the general public. This paper is a study of the results already produced by these new influences as indicated by certain figures with regard to alcoholism, alcoholic psychoses, and paresis in the state of New York during the years 1909-1920.

The effect of the reaction against alcohol is strikingly illustrated by the following table (Table 1) which shows "the percentage distribution by years of 77,334 cases of alcoholism (exclusive of psychoses) treated in the Bellevue alcoholic wards. The comparison is made with the total number of patients treated annually in Bellevue Hospital, exclusive of cases of accident and injury."

TABLE 1.—NUMBER AND PERCENTAGE OF CASES OF ALCOHOLISM AMONG TOTAL NUMBER OF PATIENTS TREATED AT BELLEVUE HOSPITAL

	Total No. of Patients Treated in Bellevue Hospital*	Number of Cases of Alcoholism**	Per Cent of Alcoholism
1909.	35,295	9,607	27.2
1910.	33,677	10,691	31.7
1911.	30,151	8,348	27.7
1912.	32,541	8,000	24.6
1913.	32,712	7,732	23.6
1914.	34,073	6,869	20.1
1915.	43,111	6,157	14.3
1916.	40,562	7,086	17.5
1917.	40,605	5,849	14.4
1918.	37,222	2,525	6.7
1919.	33,826	2,469	7.3
1920.	34,034	2,001	5.8
Total.	427,809	77,334	

* Exclusive of traumatisms.

** Cases diagnosed acute and chronic alcoholism, the definite alcoholic psychoses, are not included.

"This table shows a remarkable fall from the high point of 1910, when 31.7 per cent of all cases passing through Bellevue Hospital were diagnosed as 'alcoholism,' to the low point in 1920, when only 5.8 per cent were so diagnosed. . . . The continuous decrease in the ratio of alcoholic cases is all the more significant when we take into consideration the fact that the population of New York City has been steadily increasing and that there has been apparently no important shifting of alcoholics to other hospitals or institutions for treatment."

Chart 1 is a graphic representation of the main points of interest in Table 1. "The slight upward turn of the curve in 1919 is due to a relative increase of cases of alcoholism, the result of a falling off of the total general admissions to Bellevue Hospital. As a matter of fact, the actual number of alcoholics in 1919, as shown in Table 1, was less than in the preceding year, and the number for 1920 is the lowest yet reached." The noticeable rise in 1916—which has a corresponding rise in the curve for alcoholic psychoses shown in Chart 2—was probably largely due to the tension and unrest of the period immediately preceding the entrance of the United States into the World War. As soon as that issue had been definitely settled, the decline both in cases of alcoholism and in alcoholic psychoses set in again and has continued ever since.

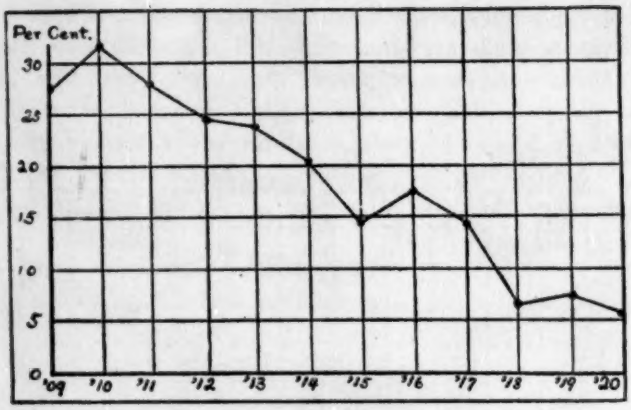


Chart 1.—Annual percentage of cases diagnosed as alcoholism among total patients treated at Bellevue Hospital

Table 2 shows the percentage distribution by years of the cases of alcoholic psychoses admitted to the New York state hospitals. Comparison is made with the total annual first admissions to these hospitals.

TABLE 2.—NUMBER AND PERCENTAGE OF ALCOHOLIC PSYCHOSES AMONG FIRST ADMISSIONS IN NEW YORK STATE HOSPITALS

Year	Total First Admissions	Alcoholic Psychoses	Per Cent of Alcoholic Psychoses
1909.	5,222	561	10.7
1910.	5,564	583	10.5
1911.	5,700	591	10.4
1912.	5,742	565	9.8
1913.	6,061	572	9.4
1914.	6,265	464	7.4
1915.	6,204	345	5.6
1916.	4,903*	297*	6.1
1917.	6,877	594	8.6
1918.	6,797	354	5.2
1919.	6,791	269	3.9
1920.	6,573	122	1.8
Total.	72,699	5,317	

* Figures for a period of nine months only, owing to change in hospital year.

"The accuracy and significance of these data are enhanced by the fact that the figures include only *first* admissions. . . . By thus eliminating readmissions we get as accurate a record as possible of the number of fresh psychoses developing each year in the community."

Chart 2 represents graphically the ratios contained in Table 2. To meet the possible argument that the decline in the number of cases of alcoholic psychosis reported by the hospitals might be partly due to a change in diagnostic attitude, a separate curve—the lower curve in Chart 2—was plotted for the Korsakoff cases, since "in that

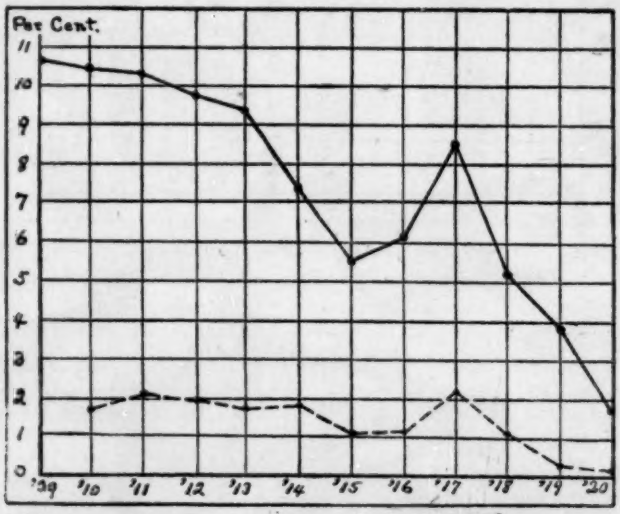


Chart 2.—Annual percentage of alcoholic psychoses among first admissions to New York state hospitals: solid line, total alcoholic psychoses; broken line, Korsakoff's psychosis

type, with its characteristic physical and mental picture, the margin of diagnostic error would certainly be reduced to a minimum." The fact that the Korsakoff curve follows in a remarkable way the curve of the total alcoholic psychoses confirms the opinion "that there has been a definite reduction in cases incontestably of alcoholic origin."

The statement occasionally published that alcoholism has been increased by prohibition has no basis in fact. There have been within recent months some fluctuations in the number of cases admitted to alcoholic wards in large cities, but such increases as have been reported may be regarded as merely temporary and in any case fall far below the figures of former years. "The indications are that prohibition will result in a still further reduction of the number of cases of alcoholism and alcoholic psychosis." There have been no signs, either, that the alcoholic psychoses are being replaced by other psychotic types, such as the drug psychoses. As shown in Table 2, the number of first admissions to the state hospitals has declined in the last five years, probably largely as a result of the decline in alcoholic psychoses. There has been a decrease in the number of drug psychoses also.

It is more difficult to answer the question whether the new developments of the last ten or fifteen years have had any appreciable effect upon the number of cases of neurosyphilis. It may be too soon to look for results, especially from the new methods of treatment, since neurosyphilitic lesions are not usually brought to attention until from five to fifteen years after the initial infection. Almost the only data available for study at present are those relating to the neurosyphilitic cases admitted to the state hospitals, especially the cases of paresis.

Table 3 shows the percentage distribution by years of the cases of paresis among first admissions to the New York State Hospitals for mental disease for the period 1909-1920. The comparison is made with the total annual first admissions to the state hospitals.

TABLE 3.—NUMBER AND PERCENTAGE OF CASES OF PARESIS AMONG FIRST ADMISSIONS IN NEW YORK STATE HOSPITALS

Year	Total Number of First Admissions	Cases of Paresis	Per Cent of Paresis
1909.	5,222	658	12.6
1910.	4,312*	520*	12.0
1911.	5,700	758	13.3
1912.	5,742	719	12.5
1913.	6,061	768	12.7
1914.	6,265	744	12.4
1915.	6,204	814	13.1
1916.	4,903**	640**	13.1
1917.	6,877	866	12.6
1918.	6,797	913	13.4
1919.	6,791	880	12.9
1920.	6,573	820	12.5
Total.	71,447	9,100	

* Admissions of one hospital not included, owing to error in reporting cases.
** Figures for nine months' period only, owing to change in hospital year.

This table shows that there has been little variation in the admission rate for paresis during the last twelve years; the fluctuations have been within narrow limits—a little above or a little below 13 per cent. The upper curve in Chart 3 represents this graphically. This curve shows, however, that there has been a slight decline during the last two years—from 13.4 per cent in 1918 to 12.5 per cent in 1920. Dr. Kirby is "inclined to attach some significance to this indicated decline especially when the recent census figures are utilized and the rate of paresis per hundred thousand of the general population is computed. This computation gives, according to statisticians,

a truer index of the incidence of a disease than does a ratio based on percentage of admissions."

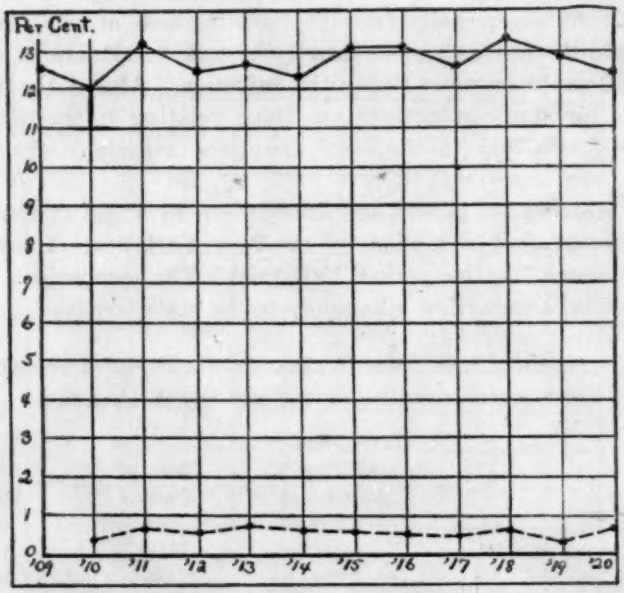


Chart 3.—Annual percentage of paresis and cerebral syphilis among first admissions to New York state hospitals: solid line, general paresis; broken line, cerebral syphilis

TABLE 4.—RATE PER 100,000 OF GENERAL POPULATION OF NEW YORK STATE OF ALCOHOLIC PSYCHOSES AND PARESIS

Year	All Psychoses	Alcoholic Psychoses	Paresis
1913. . .	64.1	6.0	8.1
1914. . .	65.4	4.8	8.1
1915. . .	64.0	3.6	8.4
1916. . .	66.5	4.0	8.7
1917. . .	69.0	6.0	8.7
1918. . .	67.3	3.5	9.0
1919. . .	66.3	2.6	8.6
1920. . .	63.3	1.2	7.9

"Reference to Table 4 shows that the rate for paresis per hundred thousand of the population of New York State was quite uniform, with, however, a slight upward tendency from 1913 to 1917; in 1918, a high rate was reached, the highest on record. Since then, however, there has been a decline, so that in 1920 we have a lower rate for paresis than at any time in the last eight years. Moreover, by refer-

ring to Table 3 we find that the actual number of cases of paresis admitted to the hospitals in 1920 was less than in 1919, considerably less than in 1918, and also smaller than in 1917. This reduction in actual numbers may perhaps be all the more significant when we consider the steady increase of the population of New York State. The suggestion has been made that the indicated decline in the number of syphilitic psychoses might be due to the more frequent retention than formerly of these cases for treatment in general hospitals. If this is actually occurring, it would hardly modify greatly the figures for the psychotic group of the entire state over a period of years unless real curative results were being obtained."

The lower curve in Chart 3 represents another, much smaller group of neurosyphilitic cases—the so-called cerebral-syphilis cases with psychosis. This group is, however, too small to be used for statistical purposes, the average number admitted during the last ten years being only 43 a year.

Dr. Kirby concludes: "From the standpoint of mental hygiene, the situation may be regarded as encouraging. A notable advance has been made in the direction of controlling one of the outstanding causes of mental disease—namely, alcoholism—and as regards a second great cause of mental disease—namely, syphilis—there are indications that education, prophylaxis, and improved methods of treatment are beginning to yield some results, as yet slight, to be sure, but nevertheless sufficient to be considered a sign of progress."

BOOK REVIEWS

FOUNDATIONS OF PSYCHIATRY. By William A. White, M.D. New York and Washington: Nervous and Mental Disease Publishing Company, 1921. (Monograph No. 32.) 136 p.

This monograph contains nine chapters with a felicitous introduction by Dr. Stewart Paton. The main text deals with: *The Unity of the Organism: The Biological Point of View—Integration—Structuralization—Individuation; The Dynamics of the Organism: The Canon of Physiology (The Conflict)—Ambivalency; The Stratification of the Organism: The Physiological, the Psychological, and the Sociological Level; The Region of Psychopathology; The Nature of the Neuroses and the Psychoses; Therapeutics: Action—Objectification—Transference—Resymbolization; The Social Problem: Elevation—Rationalization—Sublimation—The Socialization of Strivings.*

White has essayed a rather unique task. It is no less than to impress upon the medical and the lay reader the importance of the psycho-biologic view in order that the essential foundations of psychiatry may be grasped. His task is doubly difficult. In the first place, almost every medical student has been trained in the formal, academic psychology in his college preparatory course, and this manner of approach, until recently, has been to study the mind as composed of so many separate processes or faculties—will, memory, attention, etc. No attempt has been made to study the mind as a unit—as a feeling, knowing organism. Hence academic psychology leaves one cold and indifferent as to its practical uses in everyday life. Formal psychology has made little attempt to study the mind as a synthetic, integrated organism. Secondly, the average medical student is plunged still further into the analytic study of the body and mind piecemeal. Near the end of his medical course, he is suddenly required to view the body and mind as an integrated individual or personality, a living and acting organism. Some few can accomplish this right-about-face in method and gain an entirely new perspective. The majority, however, are left floundering in an effort to view the maladapted mental processes as so many defects in kidney and liver function. It is true that the organic processes do play a rôle in the induction of the psychoses, but, once initiated, the nervous disorder takes on a pattern plan according to mental laws quite distinct from the cause that incited it. The inference from the present method of study is that one has but to add up all the organismal activities *in toto* to gain a proper conception of the body as a

whole. The author points out how fallacious this conception is inasmuch as new and unpredictable functions come into being in the successive evolutional levels of development. He logically argues that the order of study ought to be reversed—the integrated, synthesized human organism first, and afterward the analytical and component parts. If such a biologic approach may result in the student's becoming concerned with the minute study of the structure and mehanism of the component parts, this does not lessen the force of the writer's contention. For a long time White has given much attention to the theory of the so-called stratification of the organism, a sort of recrudescence of the Hughlings Jackson concept. While this is a rather mechanistic view and liable to do violence to the facts, it is a manner of approach not without distinct explanatory advantages to one unacquainted with physio-psychology.

This work of White's is a thoroughly readable exposition of a difficult subject, and his digest of the literature employed in his text yields not a little supportive influence to an up-to-date account of the foundations of psychiatry. It can be thoroughly recommended to all interested in this subject. The latter half of the book is mainly a restatement of our present psychoanalytic knowledge of the neuroses and psychoses and their treatment.

L. Pierce Clark.

New York City.

The Behavior of Crowds. By Everett Dean Martin. New York: Harper and Brothers, 1920. 312 p.

Mr. Martin's book is an important contribution to the theory of crowd psychology. His elaboration of the rôle of unconscious motives and wish fancies in crowd behavior gives us a new and promising hypothesis. It remains for subsequent observers to authenticate or modify his hypothesis as additional evidence is gathered.

After touching upon some social problems of to-day in Chapter 1, the author considers in Chapter 2 how crowds are formed. The term "crowd" refers to a state of mind, a phenomenon to be classed with dreams, delusions, etc., because like them it is a device for gaining an escape from the hard realities of life. In everyday life social conventions repress and inhibit, whereas in the crowd the immediate social environment pulls in the direction of the unconscious desire. In a crowd, therefore, one can indulge in acting on desires ordinarily inhibited, as, for example, in a lynching. Chapter 3 reviews the psychology of unconscious motivation as revealed in crowd action. Chapter 4 describes the egoism of crowd mind. In a crowd the individual transfers his repressed self-feeling to the idea of the crowd

and can then exalt himself. For example, the crowd insists on being flattered. The fanatic is a crowd man, since the evil he struggles against is the projection of his own inner conflict. The crowd is shown to be a creature of hate in Chapter 5. The crowd has delusions of persecution, ideas of self-pity, and its murder wish appears in consciousness whenever the unconscious can fabricate such a defense mechanism as will provide it with the fiction of moral justification. This analysis is applied to lynching, Americanization propaganda, patriotic crowds, etc., with considerable skill.

One dissimilarity between crowd mind and the true psychosis is that in the latter the inadequately repressed wish is disguised by some mechanism, whereas in the former the repressed impulse is permitted to escape because the immediate social environment which is ordinarily a check relaxes repression.

The absolutism of the crowd mind is analyzed in Chapter 6. Just as rationalism and idealism in philosophy provide certain persons with a system of ideas in which they may take refuge from reality, so the radical crowd substitutes for the shifting phenomena of our empirical world a closed system of ideas which consists of easy generalizations and satisfying abstractions. The author does not attempt to reconcile this view with the experience of prison reform, in which it has been shown that personality is enlarged and strengthened when loyalty is transferred from the person (the concrete), as under the honor system, to a group (the abstract), as under self-government.

Revolutionary crowds (Chapter 7) are chiefly devices for sustaining the self-feeling of their members and only secondarily instruments for dealing with complex social situations. Revolution is the phenomenon of two crowd minds in conflict—a dominant crowd and an under crowd. Revolutionary propaganda is a symptom of disintegration of the system of control by the dominant crowd. Revolutionary crowds are motivated by the dream of an ideal society. The fulfillment of this dream will bring the millenium, but mere contemplation of it gives an escape from reality.

To the student of crowd psychology who reads this book, the question arises: Does crowd mind in its heightened state arise apart from actual gatherings of people in physical contact? Mr. Martin seems to think so, for he speaks of permanent crowds. This question is an important once, since social psychologists have heretofore pointed out that the heightened suggestibility and weakened inhibitions of the crowd are connected with bodily conditions of fatigue and irritation resulting from the close contact of its members. If any differences exist between crowd mind and the formation of the crowd mob, Mr.

Martin does not make clear whether he considers the difference to be one of degree or of kind. Ross distinguishes the public from the crowd on the basis of the factor of actual assemblage. This question is an interesting one, since the nature of the answer to it would help to determine whether the biological function of the crowd—its service as a defense mechanism—gives it a strong degree of survival value.

In Chapter 8 the author discusses the fruits of revolution and new crowd tyrannies for old. The reaction and disillusionment that come after revolution require new defenses to be erected against the inevitable disclosure of the fact that people are not behaving as if the Kingdom of Heaven had really come.

Chapter 9 considers freedom and government by crowds. Chapter 10 discusses education as a cure for crowd mind. It is shown that traditional education confirms crowd mind since it really does little more than systematize crowd thinking. To be a cure of crowd-mindedness, education must begin with the individual and that individual must be "myself." It is through education by doing and also by the training of the critical faculty that immunity from crowd thinking is to be had.

F. Stuart Chapin.

Smith College.

Character Training in Childhood. By Mary S. Haviland. Boston: Small, Maynard, and Company, 1921. 296 p.

This is a book full of common sense and one that young mothers will find well worth several readings. The thought is clearly expressed, the case illustrations are interesting, and the posters are "good advertising." It is unfortunate, however, that the author has not taken into consideration the fact, so clearly demonstrated in studies of children, that children's subjective feelings of inferiority to others or their feelings of guilt about something are frequently the determinants of conduct disorders.

The author deals only with those inherent characteristics which are from an ethical point of view commendable and right; and she dismisses all the other inherent traits with the statement, "Unfortunately, there is a perverse streak in human nature that makes most of us hanker after unwholesome things." Again she says, "Just so the baby brain may acquire the false idea that selfishness, temper, and other ugly traits pay, and in later years this idea can be altered only by a painful wrenching and breaking process that means infinite trouble and suffering for both parent and child." A reader will have to suppose that she does not deal with such things as hate, jealousy, fear, and sex emotions in children. She ignores them in

her book. She presents many *credenda* for children, but she omits the *agenda* on the part of the children.

She takes the behaviorists' point of view in describing the physical behavior of children, but she in no case tells of their subjective mental behavior. In two instances, however, children do actually tell the secret, but the author apparently fails to appreciate the import. In one case, seven-year-old Helen (page 85) was troublesomely dependent until Miss Haviland answered her wistful question, "Babies are much cunninger than little girls, aren't they?" by assuring her of recognition and attention as a little girl such as she would not get if she were a baby. Helen had a feeling of inferiority because she was not "cunning," and undoubtedly had to use the mechanism of dependence in order to get attention.

A second instance is that of Jimmie, aged twelve (page 163). His mother could not train Jimmie to make his bed satisfactorily. Finally his uncle undertook the task. Jimmie told him that he had thought only girls made beds, but after he learned that bed making was compatible with manliness, he was willing to make his own bed properly. But probably his uncle, his mother, and the author did not appreciate that it was an idea of inferiority on Jimmie's part that he was fighting. In his own mind, Jimmie did not want to feel inferior to his standard of what boys ought to do. I think it is likely that Jimmie had another feeling of inferiority antedating this, and that although he may have made his bed after his uncle left, his mother did not find him perfect. How much simpler it would have been all around if, instead of Helen's being trained to be independent, and Jimmie's being trained to make beds, according to adult standards, Helen's mother had asked her *why* she wanted to to be dependent or *why* she didn't want to grow up, and Jimmie had been given a chance to tell *why* he did not want to make beds and to overcome his feelings of not being manly.

In the rest of the book the reader is given no idea of the reason for difficulties arising from children's having to meet the expectations of their trainers. For example, little Julia, the colored girl, was obstinate about something and refused an explanation of her conduct. Balked, Miss Haviland said that since Julia acted like a baby, she would have to sleep in the babies' dormitory. Julia refused to go, and so she was locked up and a second endurance test was started. Every now and then Julia was asked to go upstairs, and after six hours Julia was ready. Miss Haviland won, but she won on an issue that was totally irrelevant to the first issue—namely, obstinacy about the explanation. She contends that afterward Julia gave her no more trouble. That may be, for Julia had probably learned her les-

son with Miss Haviland; but would Julia never be obstinate with another person? Did she not get a training in the idea that she had to be conquered before she would be good? Miss Haviland won out in her determination to have Julia sleep with the babies, but Julia won out in her determination not to talk. The reader surmises that Julia never told her.

The author presents a most excellent idea on page 43: "Growth cannot be forced from without—it must be fostered from within;" but elsewhere in the book she seems to superimpose virtues and ideals on top of what may already exist. Miss Haviland's friend of page 84 has a shrinking from voicing her ideas publicly because she has never made the effort successfully. The author says, "If she would once summon her will to make the effort, the chances are that she would succeed." I do not believe her friend could summon her will to make the effort; if she could, it is likely that she would, without any prodding. I think her friend's real problem in life is not facing a listening public, but facing life; some other problem is distressing her.

Character is trained, the reader gains from this book, by a development of work, play, and religion. Although readers have been accustomed to hearing of a fourth agent—namely, love—Miss Haviland omits that altogether; not even does she encourage a toleration of a child's playmates, teachers, or parents.

She says, "Light work is very desirable both for the exercise it gives and because it occupies the mind and prevents the blues." Psychiatrists believe that play and work simply distract attention from the source of the blues, as well as from the blues themselves, and that they distract attention only temporarily and do not ever in themselves settle one's original problem. Light work and play are only procrastination as regards settling the blues.

The author says that the slum is the creator of the irreverent and lawless, and a reverent spirit cannot be built up in surroundings that are not beautiful. Does she forget that "the colonel's lady and Judy O'Grady are sisters under their skins?" Does she forget that the "tough guy" can be born in a mansion, wear good clothes, and have money in his pocket? Does she not forget that the idea of the beautiful is relative and that one born in the slums might consider, without educational interference, works of art to be uninteresting, but a cheap colored print to be beautiful? Does she know the line from *Sir Launfal,* "There's never a leaf or a blade too mean to be some happy creature's palace," and the line, "Be it ever so humble, there's no place like home"?

THADDEUS H. AMES.

New York City.

RELIGION AND THE NEW PSYCHOLOGY; A PSYCHOANALYTIC STUDY OF RELIGION. By Walter Samuel Swisher, B.D. Boston: Marshall Jones Company, 1920. 255 p.

Considered as a popular discussion of an important problem, this is an excellent little book. It is all that one can expect in a book written by a layman (neither physician nor ethnologist) on a subject that interests the general thinking public intensely and yet demands a knowledge technical and extensive for its accurate exposition. The author has gathered his material from a small range of psychoanalytic literature, which seems to have provided him not only with his clinical and psychopathological data, but also with his mythological and sociological lore. The psychoanalysts consulted have garnered their knowledge as to savage life and custom from Frazer and similar uncritical compilers of secondhand reports. In consequence of these repeated selections of evidence, the finished product is, inevitably, dogmatic rather than critical. It would be unfair, however, to condemn the work on this account. The problem is so broad and so technical that it will probably be years before it is discussed in a scholarly way. In the meantime certain broad principles should be published in which intelligent people are interested and, on the whole, these principles are truthfully and fearlessly set forth by this clergyman.

In his introduction he points out that a sharp distinction must be drawn between mental mechanisms and mental content and that, therefore, there can be nothing disruptive of true religious faith in a discussion of the way man thinks religiously. The form in which man casts his belief in unseen powers, or the neurotic or insane use he may make of his creed, has nothing whatever to do with the question of the existence or nonexistence of God. In other words, it is only the spurious in religion that can suffer from psychological analysis. It might have been better had he repeated this statement at various points throughout the book, to obviate the danger of shocking the devout follower of some modern sect, who is apt to need restimulation of his logical faculty during the discussion of such a topic as this.

The argument of the book may be briefly digested.

Primitive religion is not ethical, for the savage is a creature of appetites. Good and bad fortune are the work of the "gods," and "sin" is simply an activity that may arouse the capricious wrath of a jealous god. Religious myths are sexual in origin (for instance, the widespread Adam and Eve story) and the ubiquitousness of sex accounts for the universal appearance of similar primitive religious beliefs. "Conviction of sin" is an echo of inner conflict, and this conflict does not appear till, in the process of evolution and civiliza-

tion, organized society appears. This society forces a conflict between the needs of the individual and the needs of the group. One type of cravings has to go, and the personal instincts are repressed. Thus is born the "unconscious," which contains primitive impulses. In modern man dreams reproduce the primitive sex myths, providing an outlet for this repressed material. All religions begin with phallic worship and tend to keep the phallic symbol in the foreground of their ritual.

He next gives a fair presentation of the conventional Freudian hypotheses of repression, the unconscious, the universal sex content, and so on. Then the argument proceeds: religion is primarily emotional; emotions arise in the unconscious; therefore, religion is of necessity much influenced by unconscious forces. He explains certain features of Christianity on this basis. The Jews were a people suffering from national repression on the part of the Romans. To them a belief in deliverance, in a new world, was a natural development. To these people Christ preached a religion of sane expression and love. Immediately on His death, however, disciples, particularly Paul, who were demonstrably neurotic, grafted onto this simple teaching various inhibitions, which were accepted as essential to Christianity. At the same time the persecuted Jews seized on the new religion as a vehicle of expression for their national ambitions. Hence came the future-life elaborations of Christianity and its ascetic, emasculating restrictions.

Then he goes on to a discussion of motives from the usual psychoanalytic standpoint, and this leads to consideration of the age-old problem of free will versus determinism. Consciously we may not seem to have free will, but this is because we are dominated by the unconscious. But choice has been exercised in the division of ideas between the conscious and the unconscious minds. Hence, by including the latter category, we are seen to have more free will than at first sight appears. [So far as it goes, this argument seems specious.] He then applies the hypothesis of the unconscious to other religious questions. Mysticism is demonstrated to be an expression of repressed sexuality to which it gives an outlet. Then there is the problem of evil. This may be looked on as external or cosmic for one type, and for another as internal or human. It is the latter which he analyzes. The idea of original sin comes from the unconscious, which is vaguely recognized as an evil force. Another evil is seen in morbid fears. These may be caused by forcing ethical standards on a child not developed sufficiently for their assimilation; by threats of punishment for infractions of this artificial code; by poor sex education, with its inevitable sequels; by bad advice from physicians ignorant of psycho-

pathology. These are objective, remediable influences which work to produce a sense of inborn wickedness. If such "evils" were prevented from developing, there would be much less talk of the "evil" that has bulked so large in the discussion of theology.

His next division has to do with bizarre religious movements or practices. First there is the unconscious sadistic tendency which accounts for religious persecution and the persistent repression of innocent pleasure for pleasure's sake. Its counterpart is the unconscious masochism which backs the ambition to be a martyr. A good statement is made about religious insanity in general. It is not religion *per se* that drives a patient insane, but religion used pathologically as an outlet for abnormal tendencies. Important religious movements have to do with occultism. As to this he says that one does not need to discuss at this point whether there is such a thing as survival after death or not. The important thing to recognize is that the unconscious seems to be the medium through which alleged evidence of survival is produced and that it has frequently been proved that the unconscious manufactured the evidence. The attraction occultism has for many people is in its representing a flight from reality. Sudden conversion is another phenomenon to be studied. It is potentially present in the unconscious fantasy of rebirth. A clinical parallel is found in recovery during psychoanalytic treatment, when the conflict is transferred to the physician, just as the convert is content to leave it all to God and gains an analogous mental relief. [This view of the mechanism of cure in psychoanalysis is established more by repeated statement than by logical argument. The peace of mind engendered by successful psychoanalysis and that resulting from conversion are largely the same symptomatically, but the psychological mechanisms that produce one or the other are too intricate to be disproved of in this summary manner.]

The failure of the modern churches is due, Swisher thinks, to a clinging to the old beliefs in "sin," vicarious sacrifice, the need for repression, and so on. All of these are neurotic or primitive beliefs which modern culture has outgrown. An attempt has been made to combine religion with medicine in the various forms of faith healing, some of which are based on superstition and some on a conscious effort to utilize the teachings of psychopathology. In all cases the conditions remedied are essentially neuroses of the hysterical order, and the mechanism of recovery is that of suggestion. The author is evidently sympathetic towards such a program as that of the Emanuel Movement, where religion may be combined with an honest effort to use the scientific methods of modern psychotherapy.

Finally he speaks of religious problems in education. There may be reëducation of adults by psychoanalysis, or psychoanalytic insight may aid greatly in the education of children. All psychoanalytic truths are capable of use in religious training. The Bible should not be made a fetish, but its true meaning and history understood. Moral truths should be implanted only on a properly developed and prepared soil. He also suggests that biblical stories and precepts may be used as a basis for sex education.

Two appendices present evidence as to dream mechanisms and birth dreams.

If Swisher's authorities are drawn from a narrow group, his conception of religion is equally narrow. Throughout, his idea is that of an intensely individual faith elaborated to meet individual needs. As a matter of fact, the most primitive religions open for inspection to-day show more of group than individual psychology in their make-up. The rôle of herd instinct as a basis for religious feeling in general, as a component in all individual conflicts, as a factor in mystical and occult experience—all this is omitted. The author speaks as a preacher rather than a student, for his tone is everywhere dogmatic. For instance, he says, " . . . it is true that all our psychic life is in the broadest sense based on sex. . . ." Freud has never gone so far as that. Similarly he states that all religion is phallic in origin. He is, of course, unaware that an important school of ethnologists claims that phallic symbolism occurs only in the path of megolithic culture.

The scientific faith of the author seems to be that there is but one Freud and that Coriat is his prophet. This sums up the deficiencies of the book. If one were to discard it for this reason, a grave mistake would be made. It is not written for scholars. A really critical dissertation might bore those who can derive great profit from a perusal of Swisher's work. The problem of reconciling religion and modern psychopathology is urgent for many people. They can learn here how it *may* be done. And if the reconciliation be performed exegetically rather than analytically, that is the method ninety-nine people out of a hundred prefer and get most out of. So we wish it success in its proper field.

J. T. MacCurdy.

New York City.

THE PROBLEM OF NERVOUS BREAKDOWN. By Edwin Ash, M.D. New York: The Macmillan Company, 1920. 119 p.

In reviewing Dr. Ash's book, one is impressed with the fact that the author draws his material from a long and varied experience with the nervously ill and indisposed and that this work is an attempt to lay faithfully before the reader in a simple and popular style the results of his experience, without recourse to fads or pet systems to make it interesting.

He discusses in detail the superficial and palpable causes of nervous breakdowns, and his descriptions of the various types of nervous disorders show an intimate acquaintance with their symptomatology. He devotes a chapter each to *The Neurasthenic Condition, Morbid Fears and Doubts,* and *Nervous Indigestion.* To hysteria and multiple personality he devotes three chapters. On treatment he deals justly and fairly with drugs, electricity, massage, and suggestion. To "the rest cure" he devotes three chapters. Diet and recreation likewise receive attention. In the above respects Dr. Ash's book does not differ, except in so far as it is conservative, from the many popular works that have appeared in recent years.

What one does find lacking in this work, in common with so many similar books on this problem, is a lack of understanding of the problem from a biological viewpoint. After all, it is not domestic and financial difficulties with their attendant worries, or grief and shock at the death of relatives or dear friends, that bring about nervous breakdowns, but it is some underlying lack of or defect in biological adjustment that makes it possible for these worries or shock to precipitate a nervous breakdown. Neither is it the rest cure, diet, or recreation that cures the patient, but a better adaptation to the underlying cause, or the latter's removal, in many cases without the patient's being aware of it, or by the patient's gaining a clear insight into the real difficulties and knowingly correcting and surmounting them.

Education and enlightenment in assisting the patient to "know himself" are rather more important than the rest cure. Enumeration of symptoms and reiterations that worry, etc. are causes of nervous breakdowns are hardly justified in any work at the present time unless the mechanisms that operate to bring about mental ill health are simply and plainly set forth. In this respect Dr. Ash has failed to state, elucidate, and give helpful advice on the problem of the nervous breakdown.

M. W. RAYNOR.

Manhattan State Hospital.

STUDIES ON INBREEDING. By Helen Dean King, Ph.D. Philadelphia: Wistar Institute of Anatomy and Biology, 1919. 175 p.

The publication is a reprint of a series of four papers that appeared originally in the May, July, October, 1918, and August, 1919, issues of the *Journal of Experimental Zoology*. The first of these papers presented the results of Dr. King's work as bearing on "the effect of inbreeding on the growth and variability in the body weight of the albino rat;" the second, the effect on "fertility and constitutional vigor;" the third on "the sex ratio;" and the fourth paper supplemented the first by a discussion of additional data from later generations. Considering the fourth paper as simply a continuation of the first, the investigations cover a series of twenty-five generations of continuous brother-sister matings, the closest possible inbreeding in mammals. Altogether the material consisted of 3,408 litters and 25,452 individuals. The work undoubtedly constitutes the most extensive as well as the most critically guarded experiment on the inbreeding of mammals that has yet been accomplished.

The first six generations of the experiment appeared to confirm the general belief, as well as the results of previous investigators, that inbreeding is distinctly deleterious in its effect. This result was discovered to be due to malnutrition and was not the result of the inbreeding *per se*. When the diet was corrected, these effects were eliminated. What, therefore, was technically an error in the setting up of the experiment proved to be a variation that threw much light on the results. By careful selection of the breeding animals, not only was degeneration avoided, but in the characters considered there was marked improvement. In body weight the later generations showed definite increase with decreased variability. As to fertility and constitutional vigor, the balance was also in favor of the inbreds.

The problem of the sex ratio is, of course, an entirely different question. Two strains of the inbred stock were maintained—strain A, selected for excess of males, and strain B, for excess of females. These strains were shown to remain distinct as to maleness or femaleness generation after generation, so that this character in the rat appears to be "amenable to selection." Inbreeding as a whole, however, tends to an excess of females. Discussion of these results leads to many questions which Dr. King has sought to answer by a special series of experiments since reported elsewhere.

The investigation gives increased weight to the present tendency of biological workers to regard the effects of inbreeding as essentially a genetical more than a physiological phenomenon. Dr. King's work is an important contribution to science as furnishing a more definite understanding of the nature and effects of inbreeding, and while it

emphasizes the error of the older conception that inbreeding is inherently and indiscriminately evil, it also raises the very significant question whether indiscriminate inbreeding, such as usually characterizes cousin marriages in the human species, is not likely to prove in general more pregnant of evil than out-marriages in the same population. In other words, her work suggests that inbreeding is a highly specialized and critical form of breeding, and hence can be safely carried on only under the most rigid of control conditions. This means that the prevailing belief and popular prejudice as to the practical evil of inbreeding is well founded. The ordinary farmer and commercial poultry raiser, if he be not an expert breeder, will find it more practicable to maintain the quality of his stock if he avoid the pitfalls of too close inbreeding.

HOWARD J. BANKER.
Eugenics Record Office, Cold Spring Harbor, N. Y.

A STUDY OF WOMEN DELINQUENTS IN NEW YORK STATE. By Mabel Ruth Fernald, Mary Holmes Stevens Hayes, and Almena Dawley, with statistical chapter by Beardsley Ruml and preface by Katharine Bement Davis. New York: The Century Company, 1920. 542 p.

The purpose of this comprehensive study was to attain a more adequate understanding of women delinquents. The groups of women studied include 102 at Bedford Reformatory, 88 at Auburn State Prison, 76 at the New York Magdalen Home, 110 at the New York County Penitentiary, 109 at the New York City Workhouse, and 102 probation cases from the women's night court of Manhattan and the Bronx, making a total of 587 cases. Each group was thoroughly studied, and careful comparisons were made of the findings. The results were also compared with those found by other investigators in both delinquent and general population groups. The principal topics treated in these comparisons are nature and extent of delinquency; age; habits with respect to use of tobacco, alcohol, and drugs; general social factors; nativity and color in relation to delinquency; early home conditions and family status; educational background, occupational history, and economic efficiency; sex irregularities and mental capacity.

In one of the most valuable chapters in the book mental capacity is correlated with other factors that might influence delinquency. The authors find that the average mental capacity of women delinquents is somewhat lower than that of the average of women in the general population. They do not, however, agree with Goring that constitutional factors are of greater importance than environ-

mental factors as determinants of crime. The fact is emphasized that delinquency in women cannot be traced to any one predominant factor, but results from a large variety of interrelated causes.

The study seems to indicate that native-born colored women have the highest rate of delinquency, native-born white women a considerably lower rate, and foreign-born white women a still lower rate.

The study as a whole is a valuable contribution to our knowledge of women delinquents, and great credit is due the authors for their thorough investigation of individual cases. One could feel surer of the statistical conclusions if the number of cases studied were larger. The statistical tables and drafts are admirably presented, and the limitations of each are clearly set forth. The frequent use of standard deviations and ratios of correlations with the accompanying discussions of the probability of error makes some of the text too technical for the average reader. This painstaking statistical work, however, increases the value of the book to the student of social science.

HORATIO M. POLLOCK.

New York State Hospital Commission.

THE SECRET SPRINGS. By Harvey O'Higgins. New York and London: Harper and Brothers, 1920. 243 p.

Of late various lay writers have been running a race with the professionals to see which can convey the best understanding of psychoanalysis and yet make a book on this subject entertaining. *The Secret Springs* undoubtedly caps the sheaves of them all, for the author, an able, capable litterateur, essays to turn an amusing handspring over psychoanalysis. But the result is very unsatisfactory; it is not good reading because of the monotony of one case wonder being quite like another, nor is the exposition of any one case clearly set forth. The book depicts the chief ringmaster of psychoanalysis as a mere mountebank; he is like Colonel Sellers, or the doctor in *The Stark Monroe Letters*. There is no doubt that the book is of a light and entertaining texture, but the weave is too flimsy. Had the author not been in an all-to-evident vaudeville haste, a half dozen of any of his numerous incidents could have been made of vital dramatic moment. The work then would not have been overcrowded, and a more lasting effect would have been made upon the reader's mind. *The Secret Springs* are too shallow and brackish to refresh or greatly entertain, and certainly will not assuage a real thirst for psychologic knowledge. Compare this book with the brilliant writings of the author in other fields, where he shows a real mastery of style and motive, and see how great is his present sin.

L. PIERCE CLARK.

New York City.

MAN'S UNCONSCIOUS PASSION. By Wilfrid Lay, Ph.D. New York: Dodd, Mead, and Company, 1920. 246 p.

The author has presented in as non-technical a manner as possible the workings of the conscious and unconscious mind and its relations to passion and affection. In each chapter of the book he treats of some phase of the reaction of man's inner life of love in a developmental way. The first chapter deals with a glimpse of the unconscious life, with an interpretation of its influence upon the whole life and its reaction to pleasure-pain stimuli. One is then prepared to discuss the mechanism of unconscious and conscious passion. The author emphasizes the infantility of society in thrusting sexuality into a state of repression, since it thus becomes, according to the author, a cause of prostitution, of divorce, and of most of the disharmonies from which society now suffers.

Woman, by being compelled to repress her sexuality, manifests her emotional activities in the wrong place. Man's emotional activities also become manifest in the wrong environment. This repression which society calls forth, plus the infantile fixations through the parent-imago, forces one to retain the attachment of the past and hence prevents adjustment being made properly toward the reality of the present. The relation of the mother to the child and later the unconscious directing of the child, manifested in the Œdipus-complex or an incestuous complex producing "an aged soul in a young body," are factors Lay uses in approaching the subject of prostitution. He thus indicts the mother as responsible for man's selection of a prostitute. This carrying over of the fixation he has directed toward the perfection or imperfection of marriage. He says, "Only the man with the liberated unconscious passion is really free to achieve a union with a woman well developed physically and mentally." It is this unliberated unconscious passion that is the cause of much bitterness, gross misunderstanding, and long unhappiness.

This book will undoubtedly be accepted by the general reader. It, too, will arouse interest in the various social problems of the day. There may be a danger, however, in popularizing this subject and thus introducing into the minds of the laiety misconceptions directly related to those problems with which society has to deal. Instead of being an aid, it may ultimately become a barrier.

FREDERIC J. FARNELL.

Rhode Island Society for Mental Hygiene.

THE HUMAN FACTOR IN EDUCATION. By James Phinney Munroe. New York: The Macmillan Company, 1920. 317 p.

The Human Factor in Education cuts a wide swath. It ranges from such chapter topics as *The Real Superman, The Political Animal,* and *Child Idleness* to *College Trustees and College Faculties* and *Employing the Handicapped.* It attempts a humane interpretation of educational purposes. It is a stimulating and refreshing book filled with good sense. If the author's educational doctrine could penetrate the minds of the American teachers who need it most, and convert them to humane educational practices, countless children would call him blessed. Education is a great social business. The task of the schools is to prepare young life for future social well-being. Education, however, can be only partly given by the schools. The author's remedy for the present pedagogical uncertainty is characteristic of the book: "It is not to make the schools church schools, it is not to read more chapters of the Bible, it is not to teach formal ethics and to repeat maxims; it is to educate the teachers in such a manner and to such a degree that they shall understand what education really means; it is to give each teacher so small a number of pupils that she can establish between herself and each of them a path of understanding and of sympathy, and can send all her instruction straight along that path to the inner chambers where character is building. The essence of the remedy, however, is to emphasize and reëmphasize the fact that the home is the center and mainspring of all education, and that the father and the mother, who are the responsible heads of that home, must learn and must practice their profession as the chief and finally accountable educators of the coming citizens."

ERNEST R. GROVES.

Boston University.

STUDIES IN INDUSTRIAL PSYCHOLOGY. By E. A. Bott. No. 1: *A Point of View.* No. 2: *Juvenile Employment in Relation to Public Schools and Industries in Toronto.* (University of Toronto Studies. Psychological Series. Vol. IV.) Toronto: The University Library, 1920. 125 p.

Under the first of these two titles, Professor Bott has given a clear and concise account of the significance for the social sciences of certain phases of contemporary psychology. Special emphasis is placed on the work in individual differences and in the rôle of instinctive responses. Finally a special problem is proposed which appears to offer a field for the application of these studies—namely, the failure of the schools to prepare adequately for industrial life those children who leave school at an early age to seek employment.

The second paper of the volume reports an investigation of juvenile employment in Toronto pursued under the auspices of the Canadian National Committee for Mental Hygiene. Its findings include the following:

Neither homes nor schools in Toronto are furnishing adequate training in the moral attitudes pertinent to industry, as, for example, regularity, responsibility, and interest in proficiency and in service.

Of the children who leave school for work, 23 per cent are under fourteen, the legal age; 46.5 per cent more leave between fourteen and fourteen and one-half. Sixty-two and six-tenths per cent leave, not from economic necessity, but because in their judgment it is best to do so. Sixty-four per cent show a weakened interest in school before leaving, by diminished regularity in attendance.

Wages earned during the first year of employment show little relation to amount or quality of previous school work. This tends to increase among these children and their families the underestimation of the value of school work for an industrial career.

In the selection of first positions, children are guided largely by interest in temporary wages or by trivial grounds of preference, relatively little by any adequate consideration of their own capacities or of permanent opportunities for advancement. Similar motives of minor importance lead to frequent changes of position.

School teaching should provide increased proficiency in fundamental subjects such as arithmetic and writing, and should lay increased emphasis on important character traits such as punctuality, regularity, attentiveness, and responsibility.

Methods of promotion should be planned in a way to diminish discontent and the consequent desire to leave school.

In raising the age limit for compulsory attendance, it is important to persuade the portion of the population most affected of the advantage of the change.

Since a large proportion of the children who leave school for work take positions either immediately or within a short time as factory operatives, educational and placement policy should be adapted to this fact.

As much as possible of the knowledge that teachers and school physicians acquire about children in school should be embodied in a continuous school record. This should be supplemented by group intelligence tests, and, for special cases, by individual intelligence tests and consultations of principals with school physicians.

An organization for coöperation between parents, teachers, and employers should be established. A vocational counselor should be appointed to have active charge of vocational guidance.

A plan should be instituted whereby employers would in the initial positions give preference to children with good school records. By personal persuasion and vocational talks in school, the importance of school training should be emphasized.

Coöperative plans for further investigation and experimentation should be perfected.

David Camp Rogers.

Smith College.

The Psychology of Childhood. By Naomi Norsworthy and Mary T. Whitley. The Macmillan Company, 1920. 375 p.

This is a book designed for teachers and normal-school students, but the reviewer has found it distinctly valuable to a college class in child psychology and principles of mental hygiene. For a descriptive study of children as differentiated from adults, it is unequaled. The physiological basis of tendencies and Thorndike's classification of instincts is adhered to throughout, although the general point of view can easily be termed eclectic. One of the most agreeable features is the signally well proportioned treatment, there being no overweight upon any one aspect of the child's mental phenomena. Accordingly the dynamics to all tendencies to action are not assigned to the sex instinct, but recognition of the tremendous rôle of the latter is not confined to the single chapter so designated.

The so-called normal stages of physical and psychical sex development from earliest childhood receive careful consideration, departures therefrom not being handled in detail. Yet an attempt is made to indicate the etiology of these phenomena and suggest means of prevention and wise handling of exceptional children. Very sane opinion follows on the training of the sex activity, the time, sources, and kind of instruction that seem most effective with different individuals, and the duty of the teacher in reference to this most intricate problem.

A further satisfying feature of the book is the clarity with which it points out many fallacious popular opinions, prevalent misconceptions, and suppositions now quite contradicted by experimental evidence, such as the belief that children can memorize better than adults, that they instinctively imitate every form of behavior they see, that they instinctively fear certain animals, water, or the dark, that prenatal culture influences a child in the direction of music or what not.

The chapters devoted to the analysis of play interests, habit formation, and moral and religious tendencies are broadly conceived and profitably constructive for the young student.

Miriam C. Gould.

Vassar College.

CHILDREN'S DREAMS. By C. W. Kimmins, M.A., D.Sc. London: Longmans, Green, and Company, 1920. 126 p.

This author collected nearly six thousand dreams of children from five to eighteen years of age. Children of seven years of age and under gave a verbal account of their dreams, while children of eight years of age and over were told: "Write a true and full account of the last dream you can remember. State your age, and also say about how long ago you had the dream you have described."

While some mention is made of psychoanalysis in the introductory chapter, no attempt seems to have been made to analyze any of these dreams from a psychoanalytic standpoint; merely a classification of them was made as some element was objectively observed of "the various types of wish fulfilment and fear dreams; kinaesthetic dreams; references to fairy stories; dreams of bravery and adventure; school activities, cinemas, exciting books and death incidents; dreams in which conversations are recorded; the presence of other witnesses than the dreamer; and dreams in which the dreamer was absent," as well as the influence of the general environment upon the dream, the influence of wealth, poverty, the war, blindness, deafness, the state of intelligence of the subject, etc. Evidently the author has gone through his large collection of dreams with each of these elements or influences in mind, noting the per cent at different ages in which they occur, but without inducing the patient to enlarge upon his first account and without attempting a psychoanalytic analysis in any individual case. He draws his deductions from group study. He quotes many interesting dreams which show potential neurotic elements, although he presumes that nearly all of his subjects are free from neuroses.

His book, then, will be of interest only in part to one well informed in abnormal psychology, and cannot be very instructive to one not well informed. He advances the view that careful study of the dreams of normal children will be of great advantage in determining the best trends of ability, in effecting better education and efficiency, and in preventing neurotic or psychotic tendencies from developing further.

GLENN E. MYERS.

Los Angeles, California.

THE PASSING OF THE COUNTY JAIL. By Stewart Alfred Queen, Ph.D. Menasha: George Banta Publishing Company, 1920. 156 p.

This study consists of a consideration of the methods of dealing with misdemeanants commonly known as the county-jail system. The report is an outgrowth of work done by the author while secretary

of the California State Board of Charities and Corrections. It presents material discussed under the following headings: (a) The county-jail system; (b) Substitutes for the county-jail system; (c) Inmates of county jails, and other misdemeanants; (d) Misdemeanants and felons, an outgrowth classification; (e) A basis for individualization; (f) A unified correctional system.

The introduction purports to discuss what the author considers the way in which modern retributive justice has developed. "The offender stands from the beginning in the rôle of an enemy, or at least a source of danger to the group." "The reformer has emerged through seeing in the offender more than an enemy, and more than a piece of property." "Perhaps it was the delinquency and punishment of a kinsman or a friend that occasioned this situation, perhaps it was a personal experience," etc. The chapter on the county-jail system presents rather concisely and concretely very damning evidence of the shortsightedness and viciousness of some of our methods of handling misdemeanants. The tremendous variation in the policies of peace officers with reference to itinerant laborers and tramps, the wide range in the percentage of convictions, the great variety of sentences imposed by judges on the same men for the same offenses, etc., lead the author to suspect that the treatment of misdemeanants is determined by the disposition of the judge, his theory of punishment, or the capacity of the jail, but not by a settled policy based on knowledge of the real needs of these men.

The author calls attention to the short sentences given to jail inmates, and says, "Remembering that many have firmly fixed habits of idleness, or at the best of intermittent work, and excessive use of liquor or drugs, or other vices, the significance of these short sentences must impress itself upon us. Such habits are not broken in ten days or in thirty; much less are they replaced by industry and sobriety."

The rest of the chapter is taken up with the discussion of the physical condition of the jails, prison discipline, and the fee system, as well as the "floater" custom, in regard to which he states: "It seems apparent that no county is willing to assume the burden of caring for all petty offenders, real or alleged, who happen inside its borders. Probably no county ought to undertake this task, but somebody should, and logically that body is the state." The author mentions a certain town—Marysville, California—where one day in 1915 a large number of men, perhaps two hundred, were driven out by the officers. All in all, a very dark picture of the county-jail system is painted, but fortunately something better is already in the making.

In the chapter on substitutes for the county-jail system, the author discusses the "*outdoor work*" plan, the "*workhouse*" or "*house of*

correction," the "*local farm colony,*" probably the best example of which is the District of Columbia workhouse at Occoquan, Virginia, and the "*state farm for misdemeanants*" as developed in Massachusetts, Rhode Island, Indiana, and New York. He mentions also the specialization that has lately developed in dealing with limited groups, such as vagrants, inebriates, and prostitutes, and the efforts in Switzerland and Belgium to deal with vagrants and beggars in so-called "forced-labor colonies" and "free-labor colonies."

Finally, a most important substitute for the county-jail system is to be found in the ordinary court procedure in connection with probation and parole. The author devotes too little attention to this, probably the most important of all the various substitutes he has discussed. The remarkable progress now made by probation in the states of Massachusetts and New York he entirely overlooks. Both of these states, having official state probation commissions and large field forces of probation officers, supplying nearly every court in the states, are doing much toward changing our old methods of handling misdemeanants in jails.

The chapter on *The Inmates of County Jails and Other Misdemeanants* is the weakest part of the book. The effort of the author here is to prove that there is no misdemeanant type; he seems to have taken too seriously a statement made by some one that delinquency and mental defectiveness are synonymous terms. He publishes certain tables intended originally by the authors of the articles from which they were extracted to call attention purely to the different types of mental condition found in a clinic in the courts, and without any reference to the frequency with which these types were found amongst offenders in courts, he uses these tables as evidence of the great frequency of abnormal types among offenders, according to certain extremists—evidence in which he himself places little confidence.

He emphasizes "that there is a wide range of mental ratings among misdemeanants, and that there is nothing here by which to differentiate them from the rest of the population." His whole handling of this phase of the question is most inadequate and shows a lack of sound knowledge of psychiatric studies of jail inmates. He concludes this chapter with the following statement: "Native ability, intelligence, and education, all seem to average less than in the noncriminal population. But the misdemeanants include all grades of mentality, from imbeciles to superior individuals, from illiterates to college graduates." This all may be very true, but it is the least important consideration in connection with the mental condition of jail inmates. The great frequency of mental disease and deterioration, epilepsy and psychopathic personality, as well as feebleminded-

ness, are matters of far more importance in the way of a practical program for treating these offenders than purely the question of intellectual rating. His statements regarding the physical condition of inmates of jails also deserves to be challenged. He states that physical defects are no more frequent than among non-delinquents. It is unfortunate that the author, if he intended handling this matter at all, should not have gone over the literature on the subject of the physical condition of offenders in penal and correctional institutions.

A very strong case is made out for doing away entirely with the old and possibly outgrown classification of misdemeanants and felons. This chapter is well written and presents the evidence most convincingly.

The last chapter of the book summarizes the studies made and makes a plea for a unified correctional system. The following important propositions are made:

1. "The county-jail system is unutterably bad, but it seems to be giving away in two directions—individualization and centralization."

2. "Individual misdemeanants present so many different traits and so many different problems that no set of fixed penalties can meet their various needs. The things worth emphasizing are their individual differences and their common humanity."

3. "In no important way can misdemeanants be distinguished from felons as a group. Hence there seems to be no good reason for maintaining two distinct sets of institutions—state prisons and local jails."

4. "These facts seem to point the way very definitely toward individualization through a unified correctional system."

That sort of individualization which is both feasible and worth while is (1) "to study each offender in order to learn so far as possible in what sort of a group and under what circumstances he is likely to make successful adjustments;" (2) "to form groups of prisoners likely to develop together and to establish progressive conditions under which their development is likely to take place."

He discusses the New York plan for a clearing house at Sing Sing, and the distribution of the prisoners to the other state institutions, in the light of the findings in the case of each individual offender, and finally concludes with a model plan of a unified correctional system for California. The book contains a serious indictment of the county-jail system and helpful constructive suggestions for the better handling of misdemeanants. It is distinctly worth reading.

V. V. ANDERSON.

The National Committee for Mental Hygiene.

DIE GEISTESKRANKHEITEN DES KINDESALTERS EINSCHLESSLICH DES SCHWACHSSINNS UND DER PSYCHOPATHISCHEN KONSTITUTIONER. By Theodore Ziehen. Berlin: Reuther and Richard, 1917. 491 p.

This treatise must be regarded as a significant addition to psychiatric literature because there is a dearth of books dealing even slightly with the mental disorders of children. Ziehen observed one case of general paralysis as early as six years of age and dementia praecox at seven. He considers manic-depressive psychoses not infrequent in school children as well as hysterical psychasthenia and other psychoneurotic conditions. Epileptic deterioration is mentioned and a large group of psychopathic constitutions, including neurasthenic, obsessive, paranoid, hyperthymic, and others. In contrast to the prognosis of such conditions in adults, the author says children may recover from them or develop a defined psychosis or continue in a static phase.

He discusses four possible combinations: (1) simple psychopathic constitution, (2) feeblemindedness + psychopathic constitution, (3) psychopathic constitution + fully developed psychosis, (4) feeblemindedness + psychopathic constitution + fully developed psychosis. In terminology and classification he is not strongly influenced by Kraepelin, and his point of view, while not markedly progressive, is nevertheless interesting. The book deserves translation that it may come within the reach of more who would find it profitable.

MIRIAM C. GOULD.

Vassar College.

HARVEY HUMPHREY BAKER, UPBUILDER OF THE JUVENILE COURT. Boston: The Judge Baker Foundation, 1920. 133 p.

To those who are familiar with the part Judge Baker had in the development of juvenile courts, this book will be especially welcome. Mr. R. M. Cushman, on account of his long association with Judge Baker, is especially well fitted to write an account of Judge Baker himself, and his work.

Two contributions from the pen of Judge Baker are included in the book, one not previously published—an analysis of the statistics of the court for the first five years of its existence. It is doubly valuable because it gives both the facts and Judge Baker's interpretation.

The book closes with a modest statement of the work of the Judge Baker Foundation.

A. W. STEARNS.

The Massachusetts Society for Mental Hygiene.

NERVES AND THE MAN. By W. Charles Loosmore, M.A., Brown Scholar at Glasgow University. New York: George H. Doran Company, 1921. 219 p.

The author of this book says he knows what "nervous breakdown" really is from personal experience and the experiences of others whom he has met and dealt with. It is "a popular psychological and constructive study of nervous breakdown." There are twenty chapters, which contain, aside from its introduction, a brief description of the nervous system, the nature of "nervous breakdown," and what the author considers the causes and the remedies.

The book is written in a pleasing style. Many of the chapters contain at the end a list of valuable "Don'ts." The material is presented clearly and describes well the nervous individual, his mental uncertainty and lack of grasp, his vagueness of impressions, weakness of association, and difficulty in memory, his introspective, inverted type of personality. The author emphasizes the need for sympathy and understanding of these individuals and suggests as treatment the control of the emotions through a healthy and positive expression, relaxation through religion and play, mental control through the development of attention and the inhibitions. For those individuals with a marked feeling of inferiority and undue timidity, the chapter on *Poise and Serenity* should especially appeal. They are urged to look firmly and frankly into the eyes of another, to control the voice, to be frank, sincere, and calm, not to depreciate themselves too much, and above all to have "moderate expectations of life and a faith that life is ordered for our good." At the end of the book we read, "The mind is made for order and efficiency and peace. But it cannot put itself in order. We ourselves must do that, and though religion and a straight life can do much to further this great end, we ourselves must take the initiative, working along common-sense and psychological lines." This, in a way, summarizes the author's view.

One readily perceives that the matter contained in the book concerns what we generally understand as neurasthenia, with its many symptomatic ramifications. Whether this material covers "nerves and the man" is very questionable. If one interprets "nervous breakdown" as neurasthenia, the book should prove helpful to individuals affected with this condition; at least it can do no harm, if we exclude physical factors proper and the Freudian possibilities. Faith, hope, religion, laughter, and so on will not effect underlying physical disease. The treatise leaves little for the medical man to do.

RALPH P. TRUITT.

Illinois Society for Mental Hygiene.

AMERICAN POLICE SYSTEMS. By Raymond B. Fosdick. New York: The Century Company, 1920. 408 p.

As a companion volume to his earlier publication, *European Police Systems,* the author has now brought out *American Police Systems,* which he has written after a careful personal study of the police systems in some seventy cities in the United States. The opening chapter deals with the American police problem as compared with that of Europe, greatly to the disparagement of the former. There are, however, certain reasons for this, among which are the heterogeneity of the population as compared with the homogeneous groups of Europe; the preponderance of crime in America "due to a certain degree to the make-up of our population, quite apart from the inefficiency of our police forces;" the failure on the part of attorneys and courts to back up the police, who, after all, are but a cog in the machinery of justice; the tendency of the courts to delay; uninforceable laws, "laws in America being what the people will back up;" and, lastly, the attitude of the public, for, says Mr. Fosdick, "the weak sentimentality of the community in relation to crime and the criminal is a final factor in the failure of our administration of justice which cannot be overlooked. Offenders go unpunished and the laws are used as a shield for crime because such laxity is after all in substantial accord with public opinion. Crime is an offense not only against the individual, but against the whole structure of society. Until public opinion adjusts its own point of view on these matters, we cannot expect the courts to reflect anything better. . . . The task before us is far greater than the regeneration of our police. It is the regeneration of our whole system of administering justice and the creation of a sound public attitude toward crime."

The development of our police system from the days of the "parish constable" and "night watch" up to the present day is described, and in a clear-cut manner the author shows the various police systems as they are, bringing out in each case the reasons why each system developed as it did, pointing out its flaws, and suggesting ways in which improvement might be made.

"All police work has as its goal the *prevention* of crime. It is a matter for surprise, therefore, to learn that even were we to secure 100 per cent efficiency in our patrol and detective work, most crimes would still go unhindered. . . . The average police department is still too much merely an agency of *law enforcement,* divorced from responsibility for the *causes* of crime. Its energies are consumed in defensive measures, in efforts to correct the manifestations of crime rather than attack its roots. . . . Just as yellow fever was successfully attacked by draining the swamps and morasses where it bred,

so the attack on crime is, in part at least, a matter of eliminating the breeding places. Crime develops from contact and bad environment."

"The bulk of crime, certainly of crime against property, is committed by those who have previously been in the hands of the police. . . . Too often the attitude of society and the police has made any other career than crime impossible for an ex-convict. The handicap of his previous record, his inability to secure employment, and the constant 'hounding' by the police, make it difficult for him to rehabilitate himself and easy to continue in a life of crime."

The closing paragraph puts the matter plainly: "We have, indeed, little to be proud of. It cannot be denied that our achievement in respect to policing is sordid and unworthy. Contrasted with other countries in this regard, we stand ashamed. With all allowances for the peculiar conditions which make our task so difficult, we have made a poor job of it. Our progress has fallen far behind our needs. Successful in the organization of business and commerce, preëminent in many lines of activity, we must confess failure in the elemental responsibility laid on all peoples who call themselves civilized of preserving order in their communities. Surely in the new era upon which we are entering, with its challenge to forms of government and political faiths, the vision of America will not be blind to the grave importance of the problem and the resourcefulness of America will not be baffled in attempting the solution."

The author is especially qualified for such an undertaking, and his study gives one the impression of a very fair, unbiased picture of our police systems as they are, taking into account the difficulties encountered, unhesitatingly pointing out the serious defects of which we may well be ashamed, but giving credit where credit is due and always endeavoring to supply constructive suggestions on points where destructive criticism has been imperative. The book should awaken every American citizen who reads it—and it is to be hoped that many of them will—to a realization of existing conditions and a desire and determination to create a better system.

J. J. Joslyn.

New York School of Social Work.

How to Develop Your Will Power. By Clare Tree Major. New York: Edward J. Clode, 1920. 186 p.

This little book is not a "complete course in the development of will power" as is stated on the cover, but it is a useful and pleasing publication. It is seasoned with sound, everyday philosophy and in the majority of instances the psychology approaches the present-day teachings. The author considers the individual from the physical,

emotional, and intellectual viewpoints, and while she demonstrates that the three are closely related, she attempts to show and succeeds in showing the importance of each. The book teaches the necessity of exercising emotional control, making emotion serve the individual instead of the individual's serving it.

This work is better than most of its kind. We cannot concur with the author in some of her statements, but the fault lies in the fact that inspirational books must speak with "authority" and it is frequently difficult to make definite statements in regard to psychological theories.

The author has not presented us with any new thought, but she has presented her ideas in an agreeable manner. Her book will be of value if placed in the hands of the border-line inadequates.

WILLIAM B. TERHUNE.

Connecticut Society for Mental Hygiene.

THE FUNDAMENTAL PRINCIPLES OF LEARNING AND STUDY. By A. S. Edwards. Baltimore: Warwick and York, 1920. 239 p.

This is an unusually good selection from orthodox psychology of information valuable to parent and teacher. Education is interpreted as a process of habit formation, the success of which is measured by the permanent results it produces in the life of the individual. The form of the book is influenced by the fact that the material was first presented as lectures to college students.

The book follows the traditional normal-school type of psychology. The discussion makes no use of the knowledge of the deeper aspects of habit revealed by psychoanalysis. For example, the twofold nature of the habit problem is ignored. And yet one of the most illuminating facts regarding habit formation is the possibility, disclosed by analytic psychology, of building up in the individual a habit of external conduct and at the same time an inner hostility, perhaps unconscious, toward the habitual behavior, a hostility expressed in an increasing, deep-seated protest.

Regarding the function of the schools, the book contains easy-going assumptions, which, however well they may express the thought of the professional educator, are fortunately not as yet established sociological doctrine or the decision of public policy. An instance of this is the author's statement "that the endeavor of educators to-day is to direct the activities of children for a larger number of hours out of every twenty-four." (p. 196.) This program of extending school control and necessarily narrowing family responsibility will find vigorous opponents in those who think it better to assist the home to perform its proper functions, and who are sceptical regarding the

superior social efficiency of the schools. Their reluctance to turn more of the child's life over to the schools is due to their sympathy with Trigant Burrow's statement[1] "that the perfunctoriness and sterility of the educational systems of the day, with their deficient opportunity of outlet for the inspirational interest of the child, are the external factors which are responsible for the regressive permutations of consciousness represented in neurotic affections, whether they are presented under the negative aspect of the neuroses or in the exaggerations and distortions of the sexual instinct presented in the out-spoken perversions or in so-called normal life."

ERNEST R. GROVES.

Boston University.

PSYCHOLOGY FOR TEACHERS. By Daniel Wolford La Rue. New York: The American Book Company, 1920. 309 p.

Psychology for Teachers, as its title indicates, purposes to crowd into a niche already overfull. It presents the material that we have learned always to expect in such books. It has the customary class exercises and innumerable topics for further study. Here and there are evidences of contact with recent psychological discoveries, but for the most part it keeps to the well-beaten path. The book is well put together and deserves a place with its kind. Only the discriminating teacher, however, will get from it assistance for the practical processes of teaching.

ERNEST R. GROVES.

Boston University.

YOU CAN, BUT WILL YOU? By Orison Swett Marden. New York: Thomas Y. Crowell and Company, 1920. 338 p.

SUCCESS FUNDAMENTALS. By Orison Swett Marden. New York: Thomas Y. Crowell Company, 1920. 307 p.

These are two of thirty-eight so-called inspirational books produced by this author. The first of the two has a religious trend. One chapter is devoted to the description of a new philosophy of life, which turns out to be, after all, only a brief statement of New Thought theosophy. While many of the assertions in the book are generally accepted as true, most of the attempted scientific explanations are erroneous.

The message of the second is that health, efficient utilization of potential energy, self-analysis, and confidence are the fundamentals of success. However, these ideas are not clearly expressed, or rather,

[1] *Journal of Abnormal Psychology*, Vol. II, p. 185.

are masked by trite phrases that have little relationship to the subject under discussion. While this book is not scientifically accurate or philosophically sound, it contains many stimulating thoughts.

The book might be described as a shotgun prescription for success, and it is doubtful whether any of the ingredients are sufficiently active to produce the desired results. Success is, to a great extent, an individual concept, and its attainment is doubtless only relatively possible. If one's idea of success is to outshine neighbors, to amass money by any possible means, to cultivate selfishness, egotism, and self-deception, it is barely possible that this book might help one to realize one's desires.

WILLIAM B. TERHUNE.

Connecticut Society for Mental Hygiene.

NOTES AND COMMENTS

Alabama

Plans for the first unit of the Alabama home for mental defectives have been completed. This institution was authorized by the 1919 legislature.

California

A bill that was designed to make insanity a ground for divorce was defeated in the 1921 assembly.

District of Columbia

A bill recently introduced in Congress would establish in the Department of the Interior a bureau for the study of criminal, pauper, and defective classes. The work of this bureau would include laboratory investigations and the collection of sociological and pathological data, especially such as may be found in institutions for the above-mentioned classes. The bureau would be in charge of a director, who would have the assistance of an alienist and a psychologist.

A bill has been introduced before Congress to establish a school and home for mental defectives of the District of Columbia. This bill is identical with the one presented in 1919. The institution would be known as the Columbia Training School. It would be situated in Maryland or Virginia on a site of not over 1,500 acres. Its board of control would be composed of seven citizens of the District of Columbia, at least one of whom should be a physician with special experience in the diagnosis and treatment of mental diseases and mental deficiency.

The bill provides for the commitment by the Supreme Court of the District of Columbia of feebleminded persons of not less than six years of age, upon the petition of a relative, guardian, or any reputable citizen of the District. The hearing on the petition must be by the court and a commission, appointed by the court, consisting of two qualified physicians or one qualified physician and one qualified psychologist, and evidence shall be heard by the court without a jury. The commission must make a personal examination into the mental condition of the alleged feebleminded person, and evidence shall be heard and inquiry made into the social conditions.

This bill also provides for the admission of feebleminded and epileptics between the ages of six and twenty-one years without court procedure, upon the application of parents or legal guardians. The person making such application must provide for reimbursement for care

and treatment. Any person thus admitted shall not be retained unless in the opinion of the superintendent such person is feebleminded or epileptic.

Florida

The state institution for mental defectives and epileptics, which was authorized by the 1919 legislature, will be ready to receive patients about the middle of September.

Illinois

A bill to establish a farm colony for male mental defectives with criminal propensities was introduced in the 1921 legislature of Illinois. An appropriation of $750,000 for this purpose was included in the bill.

A bill empowering school boards to establish special classes in the public schools for children who are subnormal, delinquent, mentally deficient, blind, deaf, dumb, or crippled, was introduced in the 1921 legislature. The state of Illinois would pay the excess cost of maintenance of these classes.

A bill authorizing the governor to appoint a state psychologist was presented before the 1921 legislature. The bill states that the state psychologist must have had "adequate training in general and applied psychology, the methods employed in the mental examination of children, and the educational methods employed in teaching and training exceptional and abnormal children." His duties are defined as follows: "(1) To advise and assist school officials of the public schools in the establishment of special classes for children who are subnormal, backward, mentally deficient, delinquent, blind, deaf or crippled; (2) To suggest courses of study, educational methods, and special educational care for the different groups of abnormal children; (3) To examine, with the assistance of medical experts, when necessary, children who are subnormal, backward, mentally deficient, delinquent, blind, deaf, or crippled and recommend their placement in special classes; this service to be performed upon the request of superintendents, principals, or other school officials of the public schools of any community in the state; (4) To make reports to the Superintendent of Public Instruction at such time and in such manner as the Superintendent of Public Instruction may request."

Iowa

A law recently enacted relative to admissions to the state institution for mental defectives removes all age restrictions.

Massachusetts

An important law enacted by the 1921 legislature provides for an investigation by the Department of Mental Diseases into the mental condition of certain persons held for trial. It reads as follows: "Whenever a person is indicted by a grand jury for a capital offense or whenever a person who is known to have been indicted for any other offense more than once or to have been previously convicted of a felony is indicted by a grand jury or bound over for trial in the superior court, the clerk of the court in which the indictment is returned, or the clerk of the district court or the trial justice, as the case may be, shall give notice to the Department of Mental Diseases, and the department shall cause such person to be examined with a view to determine his mental condition and the existence of any mental disease or defect which would affect his criminal responsibility."

Some of the advantages of this law are as follows: It will tend to stop the flow of recidivists to penal institutions. It recognizes the importance, both to the individual and to the state, of attempting to understand a chronic offender instead of blindly keeping him on the legal treadmill. It provides that examination shall take place before the state has gone to the expense of a trial.

Another law, which will become effective July 1, 1923, includes psychiatry as one of the subjects in which an examination must be taken by applicants for registration as physicians in this state.

Minnesota

A bill making insanity for a period of ten years a cause for divorce, which was introduced in the 1921 legislature, failed.

Missouri

The four state hospitals for mental diseases, the state sanatorium, and the colony for feebleminded and epileptic are hereafter to be under the management of one board. This board is to be appointed by the governor with the approval of the senate and is to be composed of six persons, not more than three of whom shall belong to the same political party. The president of the board must be a person of business and executive ability. He is to have charge of the business management, with direct supervision over the stewards of the several institutions.

The board of managers must appoint a health supervisor, not one of their number, who shall be well known and skilled in psychiatry. It is not necessary for him to be a resident of Missouri at the time of his appointment. He shall prescribe the qualifications that must be possessed by appointees to the position of superintendent of any

institution coming under the supervision of the board. The superintendents of the hospitals for mental diseases and of the colony for feebleminded and epileptic must be skilled in the practice of medicine and in the treatment of mental diseases. The health supervisor has the authority to transfer employees or assistant physicians from one state institution to another. His duties are defined as follows: "The health supervisor shall maintain an office at the state capital, and it shall be his duty to supervise and direct in the manner of the treatment of the health and sanitation of the several institutions under his charge and management, and shall advise and counsel with the superintendents thereof and the several assistant physicians therein and he is authorized and it shall be his duty to see that proper scientific methods are applied in the treatment of the ailments of the inmates of the said several institutions and he may require the superintendent or any assistant physician to make such report or reports touching said institution or any patient therein as in his judgment he may deem necessary. He shall visit and carefully inspect each institution at least once every two months."

New Hampshire

Chapter 29, Laws of 1921, states that the board of trustees of the New Hampshire State Hospital shall constitute a commission in lunacy. This law became effective March 10, 1921. The title, powers, and duties of this commission were formerly vested in the state board of health.

New York

The bill to convert the reformatory at Napanoch into a state institution for male defective delinquents has been approved. This institution was transferred to the jurisdiction of the State Commission for Mental Defectives on June 1. Similar provision for women has been made at the Bedford Reformatory, by the creation of a special division for defective delinquents.

Chapter 673, Laws of 1921, permits the superintendent of any hospital for mental diseases, with the approval of the State Hospital Commission, to arrange with municipal or county officials or other persons to make the laboratory service of his hospital available to municipalities or counties nearby. This law also eliminates the necessity of personal service upon the patient, in case of court commitment, when such course is recommended by the examining physicians. It requires that the substituted service be made upon the next of kin other than the petitioner. Another provision requires the judge

to state in writing his reasons when he refuses to issue an order of commitment.

The following provision for emergency admission is included in this law: "The superintendent or physician in charge of any hospital or institution for the care and treatment of the insane, except the Matteawan and Dannemora state hospitals, may receive and retain therein as a patient any person suitable for care and treatment, on a verified petition made by any person with whom the alleged insane person may reside, or at whose house he may be, or the father or mother, husband or wife, brother or sister, or the child or next of kin available, or an officer of any well-recognized charitable institution or home or any overseer of the poor of the town or superintendent of the poor of the county in which any such person may be, accompanied by a certificate of insanity executed by a physician possessing the qualifications set forth in section eight-one, on a form prescribed by the State Hospital Commission. A person thus received at such hospital or institution shall not be detained therein more than ten days if he, or any person in his behalf, shall make written request for release, unless the superintendent or physician in charge thereof shall deem such detention necessary, and shall so certify, with the approval of the State Hospital Commission, to a judge of a court of record, who may in his discretion, forthwith, issue an order committing such person to such institution for care, custody, and treatment."

North Carolina

Chapter 183, Laws of 1921, restores the management of the state hospitals for mental diseases and the state school for the feebleminded to separate boards of directors. Formerly the state hospitals had one general board. Each board is to be responsible for the management of its institution and make its report to the governor.

A law, enacted in 1919, that would transfer to the State Hospital at Raleigh the land and buildings of the state prison, was repealed by the 1921 legislature.

Oregon

The "hygienic marriage" law, enacted by the 1921 legislature and referred to the voters of the state, was defeated by about 5,000 votes at the general election in June. This law was summarized in the April 1921 number of MENTAL HYGIENE.

Washington

An administrative code was enacted by the 1921 legislature. This code divides the state government into the following departments; (1) the department of public works, (2) the department of business control, (3) the department of efficiency, (4) the department of taxation and examination, (5) the department of health, (6) the department of conservation and development, (7) the department of labor and industries, (8) the department of agriculture, (9) the department of licenses, and (10) the department of fisheries and game.

The duties of the former board of control are taken over partly by the department of business control, partly by the department of efficiency, and partly by the department of health. One of the duties of the director of business control is to appoint a state dietitian who shall make and furnish to the department food analyses showing the relative food value, in respect to cost, of food products, and advise the department as to the quantity, comparative cost, and food values of proper diets for the inmates of the state institutions under the control of the department.

The director of this department is also authorized to appoint a supervisor of farm management, a supervisor of industrial management, and a supervisor of buildings and grounds. These officers have the supervision of the farm management, the industries, and the building program at the state institutions. The supervision of the care and treatment of patients at the state hospitals for mental diseases and at the state school for mental defectives is vested in the department of health. The duties of the director of health are thus summarized in the code: "(1) To exercise all the powers and perform all the duties now vested in, and required to be performed by, the state commissioner of health; (2) To, with the assistance of the state registrar of vital statistics, exercise all the powers and perform all the duties, in relation to the registration of vital and mortuary statistics, now vested in, and required to be performed by, the state commissioner of health, the superintendent of registration, and the state registrar; (3) To, not less often than once each six months, visit and inspect each of the state institutions, ascertain the sanitary and health condition existing at each of said institutions, require the respective governing authorities thereof to take such action as will conserve the health of all persons connected therewith, and report his findings to the governor."

The director of health, with the head physicians of the women's industrial home, the school for the feebleminded, and the state hospitals, and one woman physician to be appointed by the governor, shall constitute a board to be known as the "Institutional Board of

Health." This board has the power to visit each of these state institutions and advise the superintendent regarding care and treatment, and, with the advice and assistance of the state dietitian, prescribe general rules to provide for a healthful diet for the various classes of patients. The superintendent, however, may or may not adopt the suggestions of the institutional board of health.

West Virginia

A state institution for the treatment and training of mental defectives has been authorized by the 1921 legislature. This institution is to be known as the West Virginia Training School. The law creating it stipulates that its superintendent must be "a legally qualified physician, scientifically trained in mental medicine and of not less than five years' experience in the treatment and care of insane persons and mental defectives." He is to be appointed by the governor with the advice and consent of the senate.

Applications for commitment of persons to this school are to be made to the county mental-hygiene commission, composed of the president of the county court, the prosecuting attorney, and the clerk of the county court. A relative or any reputable citizen may make application. The commission appoints two physicians to examine both physically and mentally the alleged mental defective. These physicians shall be selected as being the most capable ones available because of knowledge of and training in mental medicine. They must certify to the commission their findings, upon a form prescribed by the state board of control. A prisoner on trial who appears to the judge to be mentally defective may be committed to the West Virginia Training School in the same manner as a mental defective for whom application is made. Mental defectives in state institutions may be committed also to this institution upon the application of a relative, guardian, or friend.

The superintendent of this institution has the right to parole any patient who has improved to such extent as no longer to be a menace to himself or others, under rules prescribed by the board of control. The law states that "the training and treatment of persons admitted to the school shall be along such educational, medical, and industrial lines as have proved most effective in approved institutions for mental defectives. The medical staff of such institution, and the medical staff of Weston, Spencer, and Huntington state hospitals, are hereby authorized to administer such medical treatment and perform such surgical operations for the inmates therein as may be necessary and expedient for the cure and prevention of mental defectiveness or disease."

National Conference of Social Work

At the last meeting of the National Conference of Social Work, which was held in Milwaukee June 22-29, it was voted that the Mental Hygiene Division of the conference be made a permanent one. This action indicates that social workers recognize the social aspects of the problems in the field of mental hygiene, although these problems are primarily those of conserving individual health and of effecting necessary adjustments between individuals and their environments.

The meetings of the Mental Hygiene Division, under the chairmanship of Dr. Thomas W. Salmon, were devoted chiefly to the mental hygiene of childhood. Special emphasis was laid upon conserving the mental health of the normal child and also on the need of understanding the emotional factors in his personality. The program of the division was presented in full in the April number of Mental Hygiene.

Mr. George A. Hastings of New York was elected chairman for the coming year and Dr. Smiley Blanton of Madison, Wisconsin, vice-chairman.

Annual Meeting of the American Medico-Psychological Association

An interesting session of the annual meeting of the American Medico-Psychological Association, held in Boston, May 31 to June 3, was devoted to the discussion of community service of hospitals. The clinical papers at this meeting were largely upon the subject of dementia praecox. The association voted to change its name from the American Medico-Psychological Association to the American Psychiatric Association. The name of the official journal was likewise changed from the *American Journal of Insanity* to the *American Journal of Psychiatry*. Dr. Albert M. Barrett, Director of the State Psychopathic Hospital, Ann Arbor, Michigan, was elected president; Dr. H. W. Mitchell, Superintendent of the State Hospital at Warren, Pennsylvania, vice-president; and Dr. C. Floyd Haviland, Superintendent of the Connecticut State Hospital, secretary. The 1922 meeting will be held in Quebec or Detroit.

Association for the Study of the Feebleminded

The Forty-fifth Annual Session of the American Association for the Study of the Feebleminded was held in Boston, May 28-31. The education and training of mental defectives and the care of mental defectives outside the institution were the subjects that received most attention in the papers. The program included also visits of inspec-

tion to the Waverley State School and the Wrentham State School. The following officers were elected: President, Dr. Joseph H. Ladd, Superintendent of the Exeter School, Slocum, R. I.; Vice-president, Dr. C. B. McNairy, Superintendent of the Caswell Training School, Kinston, N. C.; Secretary and Treasurer, Dr. Benjamin Ward Baker, Superintendent of the New Hampshire School for Feebleminded, Laconia, N. H.

California Society for Mental Hygiene

Dr. Harold W. Wright, of San Francisco, California, has been elected president of the California Society for Mental Hygiene.

The American Psychopathological Association

A program of unusual interest was presented at the annual meeting of the American Psychopathological Association, which was held at Atlantic City on June 11. The morning session was devoted to a symposium on The Relative Rôles in Psychopathology of the Ego, Herd, and Sex Instincts. Dr. Bernard Glueck, New York City, spoke on *The Ego Group;* Dr. Sanger Brown, II, New York City, on *The Herd Group;* Dr. C. Macfie Campbell, Boston, on *The Sex Group;* and Dr. John T. MacCurdy, New York City, gave a general summing up of the subject. Discussion was opened by Professor William McDougall, Boston. The papers at the afternoon session were *Le Mécanisme Psychologique de la Peur de l'Action,* by Dr. Pierre Janet, Paris; *Experimental Study of Hallucinations,* by Dr. Morton Prince, Boston; *Medical Policies as to Sex Advice,* by Dr. Adolf Meyer, Baltimore; *Sex and Hunger,* by Dr. Isador H. Coriat, Boston; and *Epileptoid or Fainting Attacks in Hypopituitism,* by Dr. L. Pierce Clark, New York City.

Scholarships in Occupation Therapy

The School of Practical Arts, Teachers' College, Columbia University, in its prospectus of courses in occupation therapy for the year 1921-22, announces that two scholarships in this subject have been offered by Montefiore Hospital. The amount of a scholarship will cover the expense of instruction at the college. Applicants should communicate with the Director of Occupations at Montefiore Hospital, Gun Hill Road, New York City. Information as to courses, living expenses, etc., can be obtained from the Secretary of Teachers' College, Columbia University.

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